Total Homecare (Yorkshire) 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

Our inspection of Total Homecare took place on 30 and 31 January 2017 and was announced. We gave the service 48 hours' notice to ensure the manager would be present. This was the first inspection of the service.

Total Homecare is a domiciliary care agency, which provides care and companionship to adults in their own homes throughout the Bradford area. The agency provides a range of services including personal care, preparing meals, shopping, domestic duties and day sitting. The registered office is located in Shipley, West Yorkshire. At the time of our inspection, the service was providing the regulated activity of personal care to 68 people.

The service requires a registered manager to be in post. 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. The registered manager had left the service in December 2016 and the deputy manager had taken over the role of manager. The deputy manager told us they were applying to register with the Care Quality Commission (CQC).

Safeguarding policies and procedures were in place although no referrals had been made. The manager understood their responsibility to notify CQC and the local authority of any safeguarding concerns and staff understood how to keep people safe from harm or abuse. However, some staff safeguarding training was out of date. Accidents and incidents were not always fully documented with outcomes and actions taken as a result.

Staffing levels were sufficient to keep people safe and safe recruitment procedures were in place to ensure staff were fit to provide care and support to vulnerable people. Some staff had been employed with only one reference obtained although new procedures were in place to prevent this happening in future. Some gaps were identified with staff training which had also been identified by the manager.

A complete list of people's medicines was included in people's care records and documented on Medicines Administration Records (MARs) in people's homes. People's medicines were administered through dossette boxed medicine systems to minimise risk of error. However, gaps were noted in a number of MARs where staff had failed to sign the record.

No quality assurance audit processes were in place to monitor, assess and improve the quality of the service.

Statutory notifications such as notification of death, serious injury or medication errors had not been made to CQC.

The service had failed to submit a Provider Information Return to the CQC, detailing key information about

the service, what the service does well and improvements they plan to make.

Staff meetings were being recommenced, as were supervisions and appraisals which had not taken place in recent months. No staff spot checks had been undertaken to ensure staff were competent in their roles.

The service was meeting the legal requirements of the Mental Capacity Act (2005) although some staff had limited knowledge of this.

People and their relatives told us staff were kind and caring and staff we spoke with had a good knowledge of people, their care and support needs and likes/dislikes.

Detailed risk assessments were in place in people's care records and plans of care formulated from these. These were clear and person centred with evidence of people's preferences, likes and dislikes although some duplication of information was evident. Nutritional guides were in place in care records where people were supported with their dietary needs. Plans of care were put in place with input from people and/or their relatives and care reviews held.

A complaints procedure was in place and we saw improvements had been made to ensure complaints were taken seriously, investigated and actions taken as a result.

The management team were committed to improve the service, had a positive approach and had formulated a service improvement plan.

We found a number of breaches of Regulations and you can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always currently safe.

Safeguarding policies and procedures were in place although no referrals had been made. Some safeguarding training was out of date although the service had identified the need to address this.

People's medicines administration was not always accurately documented.

Accidents and injuries had not always been reported appropriately with reviews of care documentation.

Staffing levels were sufficient to keep people safe and the staff recruitment was mostly safe although some staff were employed with only one reference obtained.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was in place but not always up to date. The management team was introducing spot checks to assess staff competency although these were yet to take place.

Staff supervisions and appraisals were being reintroduced as part of the service improvement plan.

People's consent to care and treatment was sought.

People were supported to maintain good health and have sufficient to eat and drink.

Is the service caring?

Good

The service was caring.

People we spoke with said staff were caring and kind.

People and/or their relatives were involved in the planning of

their care and support.

Staff respected people's dignity and treated people with respect. People's independence was encouraged wherever possible.

Is the service responsive?

Requires Improvement

The service was not always responsive although improvements were being made.

Care records were detailed and person centred although some duplication of information made it difficult to quickly source specific information. Reviews of people's care records were being undertaken and this was seen as an area for improvement by the manager.

People's personal preferences were respected.

Most people knew how to complain although some people felt complaint response could be improved.

Is the service well-led?

Inadequate

The service was not well led although improvements were being made.

Statutory notifications had not been made to CQC and a Provider Information Return had not been submitted.

No effective quality assurance or audit processes were in place.

Most people and staff told us improvements had been made to the service and the management team were committed to providing an effective service.

Total Homecare (Yorkshire) Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 and 31 January 2017 and was announced. The provider was given 48 hours' notice to ensure the manager would be present due to the location providing a domiciliary care service.

The membership of the inspection team consisted of two adult social care inspectors 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. The expert-by-experience used had experience of domiciliary care services.

Prior to the inspection we reviewed the information we held about the service. This including looking at information received about the service and any statutory notifications the service had sent us and contacting the local authority contracts and safeguarding teams. Before the inspection we had sent out questionnaires to people who use the service, their relatives and staff who worked at the service and reviewed the results of these to help inform our judgement. We had asked the provider to complete a provider information return (PIR) prior to this inspection. 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. However this had not been returned prior to the inspection.

During the inspection we used various methods to assess to quality of the service. On 30 January we spoke on the telephone with 15 people who use the service, five relatives of people using the service and interviewed seven staff members. During our visit to the provider office on 31 January we spoke with the

manager, the office co-ordinator and the care supervisor, reviewed four people's care records and other records relating to the management of the service such as staff files, training records, policies and procedures.

Requires Improvement

Is the service safe?

Our findings

None of the people we spoke with raised any safety related concerns with us. All of the people who used the service and responded to our questionnaires told us they felt safe when their care worker visited them.

The service had safeguarding policies and procedures in place in order to protect people who used the service. We spoke with the manager who told us one safeguarding referral had been made to the local authority adult protection team. From our discussions with the manager we were satisfied they understood when to make a safeguarding referral. Some staff members had received safeguarding training updates but others had not. The manager had identified this and we saw plans in place to address this. Staff we spoke with understood how to recognise and act upon allegations of abuse.

We saw the service had a file containing information about accidents and injuries, with detailed forms documenting how the accident had happened, actions taken and recommendations. We saw one accident had been documented involving a person using the service falling from a bath chair. However, no accident analysis had been completed and no information documented about a review of the person's risk assessment and care plan as a result. This showed an effective accident and incident analysis system was not in place to mitigate risks to people's safety.

The service had a detailed medicines policy and procedure in place. We reviewed some peoples' medicines records and saw staff kept a complete list of the medicines each person was prescribed to aid the administration of appropriate care. This included information on the use of topical creams and where these should be applied.

One person's relative expressed their concerns to us about recent mistakes with the administration of a specific medicine for their relative which had been given incorrectly on 4 and 5 January 2017. We spoke with the manager who told us they had conducted an investigation and the staff involved had been spoken with and had received updated medicines training.

We saw Medicine Administration Records (MARs) were returned to the office on a monthly basis for review by management. However, the manager told us they had found this had not been actioned by the previous manager and they were now reviewing these "as and when." The manager told us they were changing the MAR sheets to make them easier to understand and we saw work had been started on this.

Medicines were dispensed using boxed dossette systems which reduced the risk of medicine errors. However, we saw medicines were not consistently and accurately recorded on MARs. We checked four people's MARs and found a number of missing signatures for administration and some signatures made using a pencil which meant the signature could be rubbed out and was not a permanent record. Some daily records indicated where the medicines had been administered and others not. We also saw two people had duplicate MAR sheets in place for the same medicines which both contained signatures. We spoke with the manager who immediately investigated and found these had been dispensed correctly from the dossette

and the staff had incorrectly signed both sheets. The manager told us and we saw there was a service improvement plan in place which had identified issues with the documentation of medicines and the need for audit procedures to mitigate risk of medicine error. This was yet to be implemented.

This was a breach of Regulation 12 (1) (2) (b) (g) Health and Social Care Act (Regulated Activities) Regulations 2014.

When people came to be supported by the service they received an initial assessment of personal and environmental risk. These areas were then assessed with detailed and personalised plans with risk ratings and clear direction for staff to follow to mitigate these risks. For example, the service held information on how to gain access to people's home and to ensure their security through liaising with relatives or through the management of keys.

At the time of our visit 68 people used the service and the agency employed 35 care staff. There were sufficient care staff to meet the needs of people and staff told us they were able to complete tasks without rushing. We looked at the staffing rotas and found care workers were not overloaded with people to support during the day and they were given breaks in the middle of the day. However we noted no travel time between visits was provided to the staff. We asked the care co-ordinator about this and they told us staff would usually leave people slightly early where possible so they were not running late. This meant people did not always receive the amount of care their funding paid for. The care co-ordinator took this on board and started discussions with the registered manager.

The provider used an electronic monitoring system to record when staff started and finished their calls to people. However, this system was not always effective and logged people out after a minute or two if reception was low. When the system worked correctly it highlighted staff would usually leave people's calls early to make the next call on time. We discussed the system with the manager and care co-ordinator who told us they had recently identified the system was not sufficiently effective and would be sourcing an alternative system to make sure late calls and leaving calls early were quickly identified and responded to.

People and their relatives told us through the questionnaires and telephone interviews they were mostly satisfied with staffing arrangements and had seen an improvement over the last few weeks although a few commented about not being informed if staff were going to be late and about weekend cover.

Comments from people who used the service included, "They are pretty much on time and have never missed a call", "I have never had a missed call", "We don't know who is coming, but they are pretty well on time, no one has missed a call", "They just turn up within an hour or so of when they should. No they don't ring if they are going to be late," and, "We have regular girls and they might say 'so and so' is coming tomorrow, it is the weekends that is all mixed up."

One person's relative told us, "We have regular carers now, just four girls who know [relative's name] well. Before someone would turn up to give [relative's name] a shower that [relative's name] had never seen before and [relative's name] couldn't cope with that but not now." Other comments included, "We have a regular carer who is marvellous, she is usually on time unless there is a problem. It is the weekends that are the problem. Carers turn up one to two hours late, no one rings and they are rushed and do not listen" and, "The problem is the times; it should be 9-9.30 visit, I can come at 10.30 and they have not been and they have turned up at twenty past 11. No, they don't ring and I have done everything by the time they turn up. Sometimes they'll say 'we will see you tomorrow' and then it is someone else."

Recruitment procedures ensured staff were safe to work with people who used the service. We saw staff had

to wait until their Disclosure and Barring Service (DBS) and reference checks had been completed before they started working in the service. Records confirmed staff had a DBS check and references before they started work. However we noted some staff only had one reference. We raised this with the manager who told us all new employees were going through the new process and would provide two references.

Some people commented on staff not wearing aprons and/or gloves when providing personal care. Comments included, "They don't seem to use gloves and aprons much, since we said about it they use gloves a lot more but they ought to wear aprons I think, I mean you don't know where they have been before do you", "I have never seen any gloves or aprons, " and, "They wear gloves, no aprons." Some people we spoke with told us they thought the staff overall was an apron. However, other people told us gloves and aprons were used. These comments were echoed in the results of the CQC questionnaire where a number of people and their relatives thought staff did not do all they could to prevent and control infection. One person commented, "Very few of the workers wear gloves or aprons."

Requires Improvement

Is the service effective?

Our findings

Staff received training considered essential to meet people's health and safety needs. This included training in supporting people to move, medication, dementia, food hygiene and infection control. However some staff training which required regularly updating was overdue. For example we saw some staff's training had expired in 'safer people handling', 'safeguarding', 'first aid' and 'food safety'. Some staff told us the training they had received was limited and one staff member commented they had received little or no induction or shadowing before starting work. We spoke with the manager who was aware of the problem and working towards rectifying this which we saw evidenced in the service improvement plan. Through our discussions with the manager we were confident these improvements would take place. We were told by the care co-ordinator and manager how new staff now attended a four day induction course before starting work and were completing the Care Certificate. The Care Certificate is a set of standards to equip health and social care support workers with the knowledge and skills they need to provider safe and compassionate care.

The manager told us they or the care co-ordinator checked staff competency with spot checks. However this was a new process they had just introduced so we were not able to see evidence of this on the day of inspection and staff we spoke with told us they had not received any spot checks. We saw this was marked as an action on the service improvement plan.

People we spoke with told us most staff knew how to support them. One person commented, "They all seem to know what they are doing, you get the odd one but it is usually fine," and another said, "They all seem very well trained."

Staff had been supported though supervisions and team meetings. However we noted that for many staff who received their supervision in 2017 this was their first for over 12 months. Staff also told us they had not received an annual appraisal. We mentioned this to the manager who told us they had identified staff were not supervised properly and had taken steps to address this. They said future supervisions were to be booked in every three months and staff were to have a meaningful appraisal once a year.

Due to limitations with the electronic monitoring system (ECM), late and calls where staff left early were not being identified quickly and actioned. The care co-ordinator agreed this was an area they had identified as requiring improvement and other ECM systems were being looked at.

We saw staff received their call schedules by a telephone application. Staff were provided with a work mobile phone which meant they could access their care calls at any time. Care staff received regular hours of work and allocated clients for most of the time based on their geographical location and interests. This provided continuity for people who used the service. People we spoke with told us they were getting more continuity of staff over recent weeks, apart from weekends. The provider was in the process of appointing senior staff to monitor people who used the service and manage day to day issues as well as supporting staff.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In the case of Domiciliary Care, applications must be made to the Court of Protection. The service had not needed to make any applications to the Court of Protection. We found the service was working within the principles of the MCA and the manager understood the legal requirements of MCA/DoLS and what to do if they suspected a person had become unable to make decisions, such as completing a mental health assessment and holding best interest discussions with their family. However, some staff we spoke with had an limited understanding of how these principals applied to their role and the care they provided.

We saw Information present within people's care files which demonstrated their ability to make decisions had been assessed. People and/or their relatives had been involved in decisions relating to care and support and had signed care plans. Consent documents were in place for areas such as holding keys, authorisation to view records and administration of medicines.

Daily records of care provided evidence that people were offered choices during their care and support interventions and these were respected by staff including refusals. Staff and people we spoke with confirmed our findings.

Where people were supported with nutritional needs we saw guides in place in care records to ensure staff were aware of people's dietary preferences. One person commented, "I tell them what I want when they come in, they make my meal at night, I put out what I want and they do it."

All the people we spoke with managed their own healthcare or relatives supported them with this. However, staff we spoke with understood the health care needs of the people they supported and were able to explain what they would do if concerned about someone's health, such as ringing for an ambulance in an emergency or liaising with the family, district nurse or GP. The manager told us they had not taken on some care packages where they were unable to adequately support the person's care and support needs.

We saw people had communication sections in their care records. This directed staff to their preferred method of communication. Care co-ordinators told us that staff worked with the same people where possible to build up relationships and increase the effectiveness of communication. Most staff we spoke with confirmed this. People we spoke with commented on how communication with the office had improved in the last few weeks.

Good

Is the service caring?

Our findings

All the people we spoke with including care staff, the manager and office care co-ordinators had a good understanding of people's care and support needs. They were able to share with us specific information about individuals and the support they required.

Information we received from the questionnaire and telephone interviews with people and their relatives demonstrated people thought care staff were kind and caring. Comments from people included, "The girls are lovely, very nice and caring", "The girls are nice, a couple of them are right funny; you can have a good talk with them", "They are lovely young women who come. They are very nice to me", "I have no issues with the care staff who are very good, very pleasant", "They are very nice love, I have got a nice rapport with some of them," and, "They are very nice, very helpful."

Relatives we spoke with were unanimous in their praise for care staff. Comments included, "The girls are lovely with [relative's name] and they have a nice chat to [relative's name] as they work", "The girls that come through the week are wonderful, they are very respectful and do the job really well" and, "The girls are lovely with [relative's name]."

We spoke with staff about how they would maintain people's dignity and respect and they were able to give examples such as closing curtains and doors and covering people with towels when carrying out personal care. One staff member told us of how the person they assisted with personal care laughed and joked when they insisted on covering them up but appreciated why this was needed.

We saw people had been involved in planning their care and this was confirmed by the conversations we had with people and their relatives. One person told us, "I have a care plan: we discussed that," and a relative commented, "We do have a care plan; it was what [relative's name] wanted." Care documentation was signed by people or their family members. We saw care documentation focussed on people maintaining their independence and encouraged staff to support people to undertake their own personal care and daily tasks wherever possible. We saw review meetings were held with people to ensure the care provided continued to meet their needs. We saw end of life planning in place where appropriate with implementation of the Gold Standard Framework in some people's care records. One relative we spoke with confirmed they and their relative had been involved with this.

Care coordinators understood the importance of maintaining people's confidentiality. Care co-ordinators told us they would not speak with people about other clients and ensured any information they held about people was kept safe and secure. Applications on staff phones required a separate password entry to gain access to people's information. This showed us confidentiality was important to staff.

Requires Improvement

Is the service responsive?

Our findings

From reviewing care records, speaking with people and looking at results from the questionnaire, we concluded people's support needs had been discussed and agreed with them and their family prior to the start of their care package. Initial assessments had been carried out to identify care and support required. As part of these initial assessments, information had been gathered about people's history including their jobs, hobbies and interests. For example, we saw in one person's care records information that they used to be a fashion designer. The care co-ordinator told us they had organised for them to be supported by a member of staff who had a similar interest. This led staff to be more person centred and be able to build up positive relationships.

We looked at the care records of four people who used the service. These were individualised and provided care workers with information about the person's personal history and how they wanted to receive their care and support. Care plans were reviewed as needs changed. However we found duplication of information in different sections of people's care records. This made it difficult to source specific information and for staff to review information. We discussed this with the manager who told us they were in the process of working through all care records to update them and would incorporate our findings.

We found 80% of people who used the service responded with a positive comment when asked in our questionnaire if they had been involved in decision making about their care and support. Most people and their relatives we spoke with told us they had been involved with reviewing their care and others not. For example, one relative told us, "We have a p.m. visit now and they came out and assessed that," and a person told us, "I have a care plan, we discussed that." However, another person told us, "No care plan as far as I know; there is a book that all the carers sign but that's all." We saw the reviewing of people's care records was part of the service improvement plan.

We saw people's personal preferences were respected. For example, we saw the care records detailed how one person liked to be left with two chocolate biscuits in the living room after lunch. Another person only wanted to be supported with their faith by females who had an intimate knowledge of Islam which the service had respected when allocating care staff. This showed people were supported to maintain the areas of people's life that meant a lot to them. Religion or belief is also one of the protected characteristics set out in the Equalities Act 2010.

We reviewed the responses to the questionnaire about responsiveness to complaints and we saw most people said the service and staff responded well to any complaints or concerns. Comments from people we spoke with included, "I haven't really complained and the office is quite helpful when you ring them", "I have only had to ring a few times, if I need to rearrange things they have been most helpful, I have all the phone numbers and I have never had to complain" and, "I sort things out with the office no problem." A relative told us, "Well I haven't had to speak to the office much lately but they are OK now, it used to be that they never got back to you, but they do now." However, another relative told us, "We have rung them repeatedly and they keep saying 'we will sort it out' and 'someone will be out to see you' but nothing happens." The

overall opinion from people was that the service had improved recently.

A complaints policy was in place and most people told us they were aware information on how to complain was in their care records. We saw two complaints had been received over the last 12 months. These had been taken seriously and responded to, with the complainant informed of actions taken. We spoke with one person who had complained about their relative's care and they told us they were reassured by the communication and actions taken by the new manager.

Inadequate

Is the service well-led?

Our findings

We asked people using the service and their relatives about the management of the service. These were some of the comments we received; "It's not bad really. Overall we are satisfied", "We did have a lot of issues but not now, it has improved. We are happy with the service now," and, "It has all been very good." However, some people did report they had concerns about the office not responding to their phone calls at times.

It was noticeable during our conversations with relatives and service users that although they could name some regular members of care staff, most did not know the names of the manager or office staff.

Although quality assurance documentation was available no quality assurance processes had not been put in place to analyse and drive service improvements. This meant some issues we found at inspection had not been picked up. The manager told us although they reviewed medicines administration charts where possible no formal procedure was in place. We saw issues we raised from December 2016 MAR charts had not been identified until our inspection on 31 January 2017. We saw the lack of audit process was part of the service improvement plan with actions and due dates for completion.

A Provider Information Return had been requested on 7 December with a deadline of 11 January. An email was also sent to the Nominated Individual informing them of this and stating if the details for the registered manager were incorrect they should update this. We provided a link to do so and asked them to do it within a week to ensure the manager still had enough time to complete the PIR. However, no PIR was submitted.

This was a breach of Regulation 17 (1) (2) (a) (3) (a)(b) Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

The service had failed to send CQC statutory notifications such as serious injury or death notifications.

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

Most staff we spoke with said they had noticed improvements to the service in recent weeks and felt the new manager was making positive changes. They told us morale had improved and some staff meetings had been held or planned. We some staff had responded to a staff survey in October 2016 and the manager told us they were planning to hold regular staff meetings during the year as a way to improve communication and drive best practice.

The manager told us the provider had recently been speaking with people or their relatives on the telephone or visiting in person to discuss the service. The results of this were not available on the day of inspection, however people we spoke with confirmed this had taken place.

We saw evidence of improvement and action plans in place during our inspection and from our discussions with the manager were confident these would take place. The manager and care co-ordinators told us they

were passionate about making a difference to people's service provision and they were open and honest with us during the inspection process.

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 18 Registration Regulations 2009 Notifications of other incidents The service had failed to send CQC statutory notifications such as serious injury, medication errors or death notifications. This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had failed to report incidents regarding the proper and safe management of medicines and staff had not followed policies and procedures regarding recording of administration of medicines. Regulation 12 (1) (2) (b) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to have systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The service had failed to provide a Provider Information Return. This was a breach of Regulation 17 (1) (2) (a) (3)

(a)(b) Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.