Ribble Homecare

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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?	**Good**
Is the service well-led?	**Inadequate**

Overall summary

This was an announced inspection which took place on 4th and 5th March 2015. We had previously carried out an inspection in November 2013 when we found the service was meeting all the regulations we reviewed.

Ribble Homecare is registered to provide personal care to people living in their own homes. At the time of our inspection there were 15 people using the service.

The provider had a registered manager in place as required by the conditions of their registration with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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.

We identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to 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.

People told us they felt safe with the staff who supported them and that there were sufficient staff to meet their needs. They told us staff would always stay for the right

Summary of findings

amount of time and did not appear rushed. However, we found recruitment processes in the service did not protect people from the risk of staff who were unsuitable to work with vulnerable people. Staff had also not received all of the training they needed to ensure they were able to deliver effective care.

The systems in place to manage the way medicines were administered to people who used the service were not sufficiently robust to ensure people always received their medicines as prescribed.

Risk assessments had not been completed in relation to people's individual needs. Care records contained limited information for staff to follow to help ensure they provided safe and effective care to people who used the service.

People who used the service told us they could make choices about the support they received. However we found the registered manager did not have a good understanding of the principles of the Mental Capacity Act (MCA) 20015. This meant the systems in place to record whether people were able to consent to the support they needed were not sufficiently robust to ensure people's rights were protected. Staff were also confused about the rights of people to make their own decisions.

People made positive comments about the attitude and approach of staff. They told us staff were always kind, respectful and considerate. We also saw positive comments in the feedback forms people had completed regarding their experience of the service. However, we noted care records contained limited information about people's life histories or the care they would like to receive at the end of their life. **We have made a recommendation about the planning and delivery of end of life care.**

All the people we spoke with told us the care provided by the service was responsive to their needs. The registered manager was in regular contact with all the people who used the service and was able to quickly respond to any comments or suggestions from people about the care they received.

Staff told us they were happy working in the service. They told us the registered manager was approachable and always available to provide any support or advice they required.

There were systems in place to record any complaints about the service and all the people we spoke with told us they would be confident to approach the registered manager with any concerns.

Although the registered manager was completing regular 'spot checks' regarding the quality of care staff were providing, there were no other quality assurance systems in place. This had resulted in many of the shortfalls identified during the inspection.

Summary of findings

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.

Recruitment processes did not protect people who used the service from the risk of unsuitable staff.

People who used the service told us they felt safe when they received care and support and that there were sufficient staff to meet their needs.

People were not adequately protected from the risks associated with the unsafe handling of medicines.

Is the service effective?

Requires improvement

The service was not effective.

Although people who used the service were confident in the skills and abilities of staff, we found improvements needed to be made to the system to ensure staff received the training they required.

The registered manager and staff did not have an understanding of the principles and requirements of the Mental Capacity Act (MCA) 2005. This meant people's rights to make their own decisions might not be upheld.

Care records lacked the necessary detail to help ensure staff were able to provide effective care.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives gave positive feedback about staff.

People told us that staff provided the care and support they needed. Staff were said to be kind, caring and respectful of people.

Is the service responsive?

Good

The service was responsive to people's needs.

People we spoke with told us they were able to speak regularly with the registered manager regarding the care provided by the service.

Systems were in place to record and address any complaints received at the service.

Is the service well-led?

Inadequate

The service was not well-led. Although there was a registered manager in place, they did not have effective systems in place to monitor the quality of the service people received.

Summary of findings

Staff told us they enjoyed working in the service and found the registered manager to be both approachable and supportive.

Ribble 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.

We told the provider two working days before our visit that we would be coming. This was to ensure the registered manager and staff would be available to answer our questions during the inspection. On 4th March 2015 we spoke on the telephone to one person who was using the service and three relatives. On 5th March 2015 we visited the registered office for the service to meet with the registered manager. We also spoke with the provider and seven members of staff. With permission we visited three people who used the service in their own homes and spoke with one relative.

The inspection team consisted of one adult social care inspector. We had not requested the service complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. However, before our inspection we reviewed the information we held about the service including notifications the provider had sent to us. We contacted the Local Authority safeguarding team, the local commissioning team and the local Healthwatch organisation to obtain their views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. None of the organisations we contacted raised any current concerns about the service.

During the inspection we looked at the care and medication administration records for three people who were using the service. We also looked at a range of records relating to how the service was managed; these included five staff files, staff training records and policies and procedures.

Requires improvement

Is the service safe?

Our findings

All the people we spoke with told us they felt safe when they received a service from Ribble Homecare. One person told us, "I definitely feel safe when staff come; they are beyond my expectations." Relatives we spoke with told us they had no concerns about the care their family member received from Ribble Homecare. Comments relatives made to us included, "I feel [my relative] is safe with the care they get" and "I trust [staff member] and feel [my relative] is definitely safe when they come."

Although people told us they had no concerns about their safety, we found recruitment processes for the service did not protect people from the risks of unsuitable staff. We reviewed the files held for six staff employed in the service. We found that pre-employment checks had not been completed for three staff. One staff member did not have any references on file and there was only one reference on file for a second staff member. The check with the Disclosure and Barring Service (DBS) for a third staff member had been undertaken by a previous employer in August 2013 when they had started work for Ribble Homecare in March 2014. There were also no references on file for this staff member.

None of the files we reviewed contained any evidence that an interview had taken place with prospective staff where they had been asked about any gaps in their employment history or their skills and experience relevant to the post they had applied for.

The lack of effective recruitment and selection procedures was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us there were always sufficient numbers of staff available to meet their needs. They told us staff always arrived promptly and stayed for the correct amount of time. One person commented, "Staff don't rush me; they stay over the time sometimes."

Staff had received training in the safeguarding of vulnerable adults. They were able to tell us of the correct action to take should they have any concerns about a person who used the service. All the staff we spoke with told us they would feel confident to report poor practice to the registered manager or other senior staff and were certain they would be listened to.

Care records we looked at contained limited information about the risks people might experience. We were told one person supported by the service regularly tested positive for a serious bacterial infection but there was no information for staff to follow about how they should protect both themselves and people who used the service from the risk of cross infection. The care records for another person who used the service indicated they were at high risk regarding their nutritional intake but there was no risk management plan in place for staff to follow to ensure the person received the food and fluids they required. This meant there was a risk people might receive unsafe care.

The lack of risk management processes to protect people who used the service meant there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems for the administration of medicines in the service. We saw there was a policy in place to support the safe administration of medicines; this policy referred to the different levels of support staff were able to provide to ensure people who used the service received their medicines as prescribed. However, from the care records we reviewed, we found there were no care plans in place to describe the level of support individuals needed from staff in relation to their prescribed medicines. This meant there was a risk people might not receive their medicines as prescribed.

We reviewed the Medication Administration Record (MAR) charts for three people who used the service and noted staff signed to say they had given all medicines, rather than signing for each medicine separately. The registered manager told us this was because people always had their medicines dispensed in monitored dosage systems. However, we noted one MAR chart indicated staff had also administered medicines which were not in a monitored dosage system, including two different forms of 'as required' pain relief. When we discussed this with the staff concerned we were told they would usually act on the

Requires improvement

Is the service safe?

advice of a family member when administering pain relief and that there were no protocols in place for them to follow. This meant there was a risk medicines would not be administered safely.

One of the MAR charts we looked at showed that one tablet had been found on the floor at the home of a person who used the service on 31 January 2015. There was no evidence that staff had taken any action to check whether any action needed to be taken to safeguard the person concerned. The registered manager told us they were unaware of this incident although the medication policy advised staff that all medication errors should be reported to them.

One of the MAR charts we looked at showed that staff had administered a variable dose medicine for one person without recording the actual dose given on two occasions. This meant we could not be certain the person had received this medicine as prescribed.

The registered manager told us they were not completing medication audits. Such audits are important to help identify when practice needs to be improved to ensure medicines are always handled safely by staff.

The lack of appropriate arrangements in place to ensure the safe handling of medicines in the service was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

Most of the people who used the service and their relatives told us staff appeared to have the necessary skills and knowledge to be able to provide effective care. Comments people made to us included, "Staff have really promoted [my relative's] independence; their mobility is now much improved" and "Staff know what they are doing". However, one relative told us they did not think that staff were using the most up to date moving and handling techniques.

We discussed with the registered manager the moving and handling training staff had received. They told us training was completed on line before they showed staff the correct moving and handling techniques to use. However, we could not find any evidence on the registered manager's file that they had completed recent moving and handling training. They told us they had also not completed a 'train the trainers' course in moving and handling to ensure they were always advising staff of the most up to date moving and handling techniques which they should be using.

We asked the registered manager about whether staff had completed first aid training to help ensure they were able to deal with any emergencies which might arise. The registered manager could not provide any evidence that any staff had completed this training.

The provider told us they were responsible for overseeing the training staff had completed. However, there was no central record maintained of this training. The registered manager was unable to tell us what refresher training staff required. This meant there was a risk staff would not have the necessary skills to be able to provide effective care. This was a breach of regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received an induction when they started work at the service and that this had prepared them well for their roles. They told us the induction included shadowing more experienced staff and undertaking mandatory training. The records we reviewed showed staff had completed training in safeguarding vulnerable adults, moving and handling, health and safety and the safe administration of medicines.

We looked at the induction policy for the service and saw it stated that staff would be supported to complete the Skills for Care common induction standards during the first twelve weeks of their employment with the service. We looked at staff files and saw no evidence that this process was in place. We asked the provider and registered manager about this. They were unable to tell us what was meant by 'common induction standards' or how staff might be supported to achieve them. During the inspection the provider accessed the relevant on line resources and advised us all staff would be supported to complete the process as soon as possible.

The registered manager told us that the service was mainly involved in supporting people who required end of life care. Although the feedback we saw from relatives was extremely positive regarding the end of life care which had been provided to their relative, we did not see any evidence of end of life care plans in the care files we reviewed. The registered manager told us they had not undertaken any specialist training in best practice in end of life care and only one of the staff we spoke with had completed end of life training.

We recommend that the service finds out more about best practice in relation to the planning and delivery of end of life care.

We looked at the systems in place to help ensure people who used the service were asked for their consent before any support was provided. We saw that there was a consent form in place but this had been signed by relatives of people who used the service on all of the care records we reviewed. In each case, the registered manager had documented that the individual receiving the service was unable to sign the form but there was no evidence as to whether their capacity to consent to care and support had been assessed. The registered manager told us they had not sought any evidence that any relatives signing consent forms had the legal authority to do so.

We discussed the principles and requirements of the Mental Capacity Act (MCA) 2005 with the registered manager; this legislation is intended to ensure people receive the support they need to make their own decisions wherever possible. The registered manager told us they did not have any knowledge of this legislation or how it might impact the care and support they provided to people.

We spoke with staff about their understanding of the MCA. None of the staff we spoke with had completed training in this legislation and some staff appeared confused about

Requires improvement

Is the service effective?

whether the relatives of people who used the service had the right to make decisions on their family member's behalf. This meant there was a risk that people's rights might not be protected.

The lack of evidence that staff sought and acted in accordance with the consent of people who used the service or assessed people's capacity to make particular decisions was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records we looked at included limited guidance for staff to follow to ensure they were providing effective care. We were told that one person who used the service required staff to use a hoist in order to support them to mobilise in their home. We looked at this person's care records and although the care plan had been updated in July 2014 to indicate that the person's needs had changed, there was no detailed information in the plan for staff to follow to ensure they were effectively meeting the person's needs in relation to mobility.

One person's care records stated that they required staff to turn them four times a day. We asked the registered manager how such checks were recorded to ensure staff were providing consistent and effective care. We were told no records of positional changes were maintained because the same staff would always support the person concerned.

The lack of accurate records in relation to people who used the service was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked about the systems in place to ensure that, where the service was responsible, people were supported to have enough to eat and drink. The registered manager told us that they would always ensure staff encouraged people who used the service to choose healthy options if they supported them to shop for food.

Staff we spoke with told us they always ensured people had access to drinks. They told us, where necessary they would ensure people were weighed regularly to check they were receiving adequate nutrition.

Staff told us they worked closely with the nurses who were involved with people who used the service to ensure people's health needs were met.

Good

Is the service caring?

Our findings

People who used the service were very complimentary about the staff from Ribble Homecare. Comments people made to us included, “All the staff are very nice”, “One of the staff could come and live with me. She’s so gentle and lovely; she’s put a bit of herself into the caring” and “They are all lovely girls.”

People told us they were always treated with dignity and respect by staff. One person commented, “It’s no embarrassment to have a wash; your privacy is always respected.”

We asked staff what they understood by person centred care. Staff told us they always treated people as individuals and supported them to be as independent as possible. All the staff we spoke with demonstrated a commitment to providing quality care and support for people who used the service. One senior staff member told us, “I look after people as if they were members of my own family and expect staff to do the same. It’s people’s right to be treated like that.”

We looked at the feedback provided by people who used the service and saw positive comments had been made about staff. Comments people had made included, “Staff are very professional, approachable and caring”, “Everyone was very professional and kind during the time they were caring for [my relative]. They always showed [my relative] consideration, kindness and patience” and “We received an excellent level of service from every staff member we encountered.”

We noted that care records we reviewed included a one page profile which included some information about the wishes and preferences of the person regarding the care and support they needed. However, the profiles did not include any information about people’s previous life history; such information is important to help staff develop caring and meaningful relationships with the people they support.

Good

Is the service responsive?

Our findings

People told us the care and support provided by Ribble Homecare was flexible and responsive to their needs. One person told us, “They [staff] always do what you want. They help me a lot.” Another person commented, “They [staff] do anything and everything I want them to.”

The registered manager told us, due to the fact that referrals were often made to the service for people ready to be discharged from hospital on a ‘fast track’ basis, there was often not enough time for them to complete an initial assessment before the service started. However, the registered manager advised us that they would always meet with the person using the service as soon as they were discharged home to ensure the service was able to meet their needs. They told us they always worked closely with the district nursing service to try and ensure people were provided with any equipment they needed.

The registered manager told us they visited people who used the service regularly to check that they were happy with the care they received. We did not see any evidence on the care files we reviewed that people who used the service or their relatives had been involved in formal review meetings. However, people told us they felt able to contact the registered manager if they wished to make any changes to their care arrangements. One person told us, “If I have any problems, queries or suggestions they [the registered manager] listens to me. There is nothing I would change.” We noted that people were also asked to complete feedback forms regarding their experience of using the service and all the responses we reviewed were very positive.

We saw that people were provided with information about how to make a complaint. All the people we spoke with told us they would have no hesitation in speaking with the registered manager if they had a complaint or any concerns. A relative told us, “If there was anything wrong I would just say.”

We noted the complaints procedure for the service did not include any details regarding the response times people should expect for any complaint to be investigated. We discussed this with the provider and registered manager who agreed to amend the policy to make it clear to people who used the service how any complaint they might make would be handled. The provider showed us the records relating to the one complaint which had been received by the service. We saw appropriate action had been taken by the service to investigate the complaint.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post at the service. The manager had been registered with CQC since March 2013 when the service first registered with the commission.

People we spoke with during the inspection spoke highly of the registered manager. Comments people made to us included, "[The registered manager] comes sometimes to check what staff are doing" and "The manager has been three times to check things are ok."

The registered manager told us they considered the key achievement of the service since the last inspection had been the growth of the company and the recognition it had gained in the area. They told us they wanted the service to remain small so that they could continue to personally oversee the quality of care and support provided to people.

We asked the registered manager about any quality assurance processes in place at the service. They told us that they relied mainly on spot checks and personal contact with people who used the service to review the quality of care provided by staff. We saw that these spot checks had been completed on four of the five staff files we reviewed. We were told there was no plan of audits in place in the service; this had resulted in many of the shortfalls and breaches of regulations we had identified during the inspection.

The lack of robust systems to monitor the quality of the service people received was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the staff we spoke with told us they enjoyed working in the service and found the registered manager to be approachable and supportive. One staff member told us, "It's a good company to work for. It's not based on time."

We saw that regular staff meetings were taking place. However, when we looked at the notes from the four most recent meetings we saw that the same information was replicated on each occasion. We did not see any evidence that staff had been supported to raise any practice issues which concerned them. However, all the staff we spoke with told us they felt listened to in the meetings and considered they were able to make suggestions to improve the quality of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not have effective recruitment and selection processes in place.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not taken proper steps to ensure care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not have suitable arrangements in place to ensure that people employed for the purposes of carrying on the regulated activity are supported by receiving appropriate training.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not have suitable arrangements in place to obtain and act in accordance with the consent of people who used the service in relation to the care and treatment provided for them.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to maintain accurate records in relation to people who used the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have an effective system to regularly assess and monitor the quality of service that people received.