Unique Home Care Limited

Unique Home Care Limited

Inspection report

2 Hutton Close
South Church Enterprise Park
Bishop Auckland
County Durham
DL14 6XG
Tel: 01388773884

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Good
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We inspected this service on 16, 18, 19 and 20 March 2015 which was carried out in response to concerns raised by a health care professional. The inspection was announced. This meant the staff and acting manager knew we would be visiting. Our inspection focussed on a small number of people who a health professional had raised concerns about.

Unique Home Care Limited provides personal care to people who wish to remain independent in their own homes. The agency covers the areas of County Durham and Darlington and provides a range of home care and support services.

The agency had a registered manager in place. 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

Summary of findings

and associated Regulations about how the service is run. The registered manager was also the provider of Unique Home Care Limited. She had appointed an acting manager to undertake the day to day management of the agency. The acting manager had been in post since July 2014.

The people we visited had not had their physical and mental health needs monitored by the provider. There were no regular reviews of their health and care needs and the provider could not demonstrate how it responded to people's changing needs. Arrangements were not in place to ensure people received medication in a safe way.

We looked at people's care plans, where people had very complex needs. We found there was very little information to guide staff about how to meet these needs safely.

The staff we spoke with said that although they had induction training when they first started working for the provider, they had not had any further training since this time. These people had been recruited by the agency between 2011 and 2013. They also told us they had had very little contact with the agency since their employment, other than to hand in their time sheets, and had not received regular supervision or annual appraisals.

We viewed records which showed us that there were unsafe staff recruitment procedures in place.

The staff we met with were caring in their interactions with service users.

We saw the views of the people using the service were not regularly sought.

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?
The service was not safe.

Records showed recruitment checks were not carried out to help ensure suitable staff were employed to work with vulnerable people.

Staffing was arranged to ensure people's needs and wishes were met promptly.

Arrangements were not in place to ensure people received medication in a safe way.

Inadequate

Is the service effective?
The service was not effective.

Staff did not receive training and development, formal and informal supervision and support.

People's needs were not regularly assessed to ensure people received care and support that met their needs.

Inadequate

Is the service caring?
The service was caring.

People were supported by caring staff who respected their privacy and dignity.

Good

Is the service responsive?
The service was not responsive.

People's care plans did not reflect the complexity of the care tasks to be carried out by care staff.

There was a complaints procedure. People said they would contact the agency office if they needed to.

Inadequate

Is the service well-led?
The service was not well led.

Service users were not regularly asked for their views and their suggestions were not acted upon. Quality assurance systems were not in place for everyone to ensure the quality of care was maintained.

Inadequate

Unique Home Care Limited

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 was 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.

The inspection took place on 16, 18, 19 and 20 March 2015 and was carried out in response to concerns raised by a health care professional. The inspection was announced. This meant the staff and acting manager knew we would be visiting. The inspection was carried out by two Adult Social Care Inspectors. During our inspection we were told there were a total of 98 people using the service.

Before this inspection we reviewed notifications that we had received from the service to help us plan our inspection.

We visited three service users in their own homes and met with their care staff. We also spoke with two staff including the acting manager (who had been appointed by the provider, who was also the registered manager, to manage the service on a day to day basis). We did this to gain their views of the service provided.

We looked at four care records and five staff training and recruitment files.

For this inspection, the provider was not asked to complete 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. During the inspection we talked with people about what was good about the service and asked the acting manager what improvements they were making.

Inadequate

Is the service safe?

Our findings

The staff records we examined showed us a process was not in place to ensure safe recruitment checks were carried out before people started to work for Unique Home Care Limited. We found important information had not always been checked to make sure those using the service were not at risk from staff who were unsuitable to work with vulnerable people. For example, in the staff records we looked at, on one occasion we saw that a DBS (Disclosure and Barring Service) check had not been sought to ensure that the member of staff was suitable to work with vulnerable people. In all of the staff files we looked at there was no evidence that an interview had taken place to make sure that the staff had the right skills, experience and knowledge. In one staff file we looked at there was only one reference to verify the person's character. In another staff file we looked at there was no record of previous employment or educational history. The recruitment records we looked at were dated 2011 to 2013, before the acting manager was appointed to manage the service. This meant the provider could not be assured suitable people, with the right experience and knowledge, were employed to provide care and support to service users.

This is a breach of Regulation 21of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visits to people who used the service, we saw staff responded promptly to their needs if they required support or assistance. One person told us she had a 'flexible arrangement' with her care worker which meant she was provided with support when she needed it.

Unique Home Care Limited had a medication policy in place. The acting manager told us it was the policy of the agency to carry out a medication competency assessment on each member of staff employed for administering medication every three months. We saw that three out of the five care staff whose training records we viewed, were responsible for administering medication through a percutaneous endoscopic gastrostomy (PEG) feeding tube (PEG feeding is used where people cannot maintain adequate nutrition with oral intake) and that this was identified as a task in the NHS commissioning care plan (This meant the NHS had a contract with the provider for the care staff they recruited to administer medication in this way). However, the records showed that these staff had not had any training in relation to this task nor had any medication competency training been carried out by the agency since the contract had started. There were no records at all of medication being administered by the three care staff. One member of care staff told us they were concerned about giving medication in this way as they had not been given any training by the provider in relation to this.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and Regulation 12(c) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

We viewed four care records at the agency's office. We saw some people had very complex care needs, for example, PEG feeding tubes and severe epilepsy. We found these people's care needs had not been reviewed since they started using the care agency as far back as 2011. This meant Unique Home Care Limited could not demonstrate that effective care was being provided.

This is a breach of Regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and Regulation 9 (1) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2104.

We asked staff to describe the training and development activities they had completed at Unique Home Care Limited. Two of the three staff we spoke with told us they had not had any training since they were employed by Unique Home Care Limited. They told us they had undergone induction training which included medication training, moving and handling and equality and diversity. We saw from staff training records that this had not included any specialist training in order to provide them with the skills they needed to meet the complex needs of the people in their care. The staff training records we examined confirmed that none of the staff had received any training since they were recruited, in two instances as far back as 2011. One member of staff told us they administered medication via a PEG feeding tube. They told us they had had had no training about how to administer this safely and were told by Unique Home Care Limited that they didn't need any training because 'they were a family member'. Two out of the three staff we spoke with told us they had not received regular supervisions with a senior member staff within Unique Home Care limited. One member of staff told us they had had annual appraisal and some supervisions but we saw this was last carried out in 2012. The staff we spoke with told us they had had no contact with Unique Home Care Limited other than to submit their time sheets. This meant staff were not being assisted to complete training and development activities nor were they being supported in delivering effective care.

This is a breach of Regulation 23 9A0 and 9B) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service caring?

Our findings

The staff we met with were caring in their interactions with service users. One service user told us “I find I am treated with dignity and respect in an honest way. My confidentiality is maintained and I am treated as an individual.”

During our visits we watched staff practices as they interacted with people. We heard staff address people respectfully and explain to people the support they were providing. Staff were friendly and very polite and understood the support and communication needs of people in their care. We saw staff interacting with people in a very caring and professional way.

We found the staff treated people with dignity and respect and listened to people. For example, one service user explained how the staff always told her what they had recorded in the daily records.

Inadequate

Is the service responsive?

Our findings

We looked at the care records of people who used the service. We saw significant gaps which placed people at risk of harm. For example, some people required assistance with

PEG feeding tubes. There was no information written in the care plan to guide staff about what they needed to do to undertake this task safely. For example, in one care plan it stated 'carers to fill beaker, make and feed [name of person] her tea, minimal textured foods due to risk of choking following food hygiene policy.' There was no detailed description of how much liquid food should be administered, what temperature this should be given at, what safeguards needed to be in place and how blockages or problems should be identified and procedures for dealing with this or what to do should the person start to choke.

We saw that only one member of staff had written down the support provided to people each day in the 'daily records.' This meant Unique Home Care Limited was not able to identify changes and respond to those changes promptly.

This is a breach of Regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and Regulation 9 (1) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2104.

There was a complaints procedure. People said they would contact the agency office if they needed to. One person told us "I would discuss any concerns with the care staff first and then if we could not resolve things I would approach the care agency."

Inadequate

Is the service well-led?

Our findings

One service user told us "I made a suggestion to the agency some time ago about managing my support hours but they didn't get back to me".

The agency had a manager who was registered with the Care Quality Commission. The registered manager was also the provider. They provider/registered manager had appointed an acting manager in July 2014 who was active in the day to day running of the care agency.

Management systems were not, however, in place to ensure the care agency was well-led. For example, the acting manager confirmed she had been aware of the names of the people we spoke with but when she had asked the provider about them was told care was provided by friends and family and were a separate arrangement; therefore she was not aware of them as being part of the monitoring arrangement

The staff and service users we spoke with said they had had no contact at all with the registered manager or acting manager. There was no evidence that people's views had been sought about the care they received. There was no evidence from the staff we spoke with that they were supported through, for example, team meetings, regular supervisions or annual appraisals.

We saw risk assessments were carried out before care was delivered to a person. However, these lacked detail, given the complexity of the care to be delivered, for example, the administration of food and medication through PEG feeding tubes, and there was no evidence in any of the care records we examined, that these had been reviewed or changes made to the care plans since they were first written, in one instance as far back as 2011.

This is a breach of Regulation 10 (1) (a) and (b) and 10(2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.