Home from Home Care Services Limited

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Inspection report

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Date of inspection visit: 9 an 15 October 2015
Date of publication: 03/12/2015

Ratings

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

Overall summary

The inspection took place on 9 and 15 October 2015. The inspection was unannounced.

The service provides personal care to people in their own homes. There is an office in Holbeach, Lincolnshire. The service currently provides 1200 hours of care to people a week.

There was a registered manager in post; they were also the service provider. 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.

Summary of findings

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have enough care workers to meet people's needs and care workers did not receive effective training or support. Medicine records were not appropriately completed and risks to people while receiving care were not all identified. The provider did not fully understand their responsibilities under the Mental Capacity Act 2005 and did not respond appropriately to complaints. You can see what action we told the registered persons to take at the back of the full version of this report.

The provider did not have systems in place to monitor the quality of the service they provided. They therefore failed to identify that they were providing a poor quality service to people. They had not consistently attempted to gather the views of people using the service and therefore had not identified the impact of poor care on people. The provider failed to respond appropriately to complaints and did not review the standard of care people received to see if improvements were needed.

Care workers had received training about the Mental Capacity Act 2005, but they and the provider had not fully understood their responsibilities and therefore were unable to consistently protect people's rights.

Staffing levels were inadequate to provide safe care to people and care workers had to rush care to meet people's needs as travel time was not routinely included on the rota. Care workers did not always respect people's homes when they were rushing to provide care. Care workers had completed some training but lack of supervision and support meant that the provider had failed to recognise that care workers did not always have the skills and knowledge needed to provide safe care.

Care plans were poor and did not contain all the information care workers needed to provide safe care. In addition, they did not contain information needed to ensure care was personalised to meet people's individual needs. Medicine administration records were inconsistently completed and the provider did not identify concerns about poorly completed records.

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.

There were not enough care workers to meet people's needs and traveling time was not scheduled which meant calls were cut short and care was rushed.

Care plans did not contain information to support care workers to administer medicines safely. Medicine administration records did not clearly record which medicines needed administering and which had been administered.

Shortfalls in risk assessments meant people were not always assured of receiving safe care.

Care workers raised concerns when people were at risk of harm.

Is the service effective?

Requires improvement

The service was not always effective.

Care Workers received training however, it was not always effective and new care workers did not always receive an induction which gave them the skills needed to care for people. The provider did not complete adequate checks on people's competencies.

Care Workers received training in the Mental Capacity Act 2005. However, the provider and care workers were not always aware of how to protect the rights of people who needed support to make decisions.

Care plans did not support care workers to provide person centred care to people around their food choices. Care related to people's complex nutritional needs was not identified.

People were supported to access appropriate health care professionals.

Is the service caring?

Requires improvement

The service was not consistently caring.

Individual care workers were caring. However, when care was rushed they did not always stop to consider they were in people's home environment.

People were aware of the information in their care plan.

People were not always supported to have the care worker of their choice due to staff shortages.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

The provider did not always respond appropriately to complaints. Changes in care were not made to keep people safe.

People's care plans did not reflect their current needs and had not been updated when their needs changed. They did not contain information to enable person centred care to be delivered. There was no information to support people with interests and hobbies.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not maintain an overall view of the quality of service they provided and were not proactive in driving improvements.

The systems in place to monitor the quality of service were ineffective.

People were not supported to be involved in developing the quality of the service they received.

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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 9 and 15 October 2015 and was unannounced. We completed this inspection sooner than was originally planned as concerns had been raised with us by people who received care from the service and staff. The inspection was completed by a single inspector.

Before the inspection we reviewed notifications of incidents that the registered persons had sent us since the last inspection. We also spoke with the local authority who commission care from the provider to gather their views of the service provided.

We visited the provider's administrative offices on 9 October 2015 and spoke with the registered manager, assistant manager and three office staff. We looked at the care plans for five people and looked at records relating to the administration of medicines. We also looked at management information such as staff records, staff rotas, complains and any records related to quality checks performed by the provider.

As part of the inspection we spoke by telephone with four people who received care from the provider and three relatives of people who received care. We also spoke by telephone with four care workers.

Requires improvement

Is the service safe?

Our findings

The provider did not deploy care workers to reliably meet people's needs. People told us that the time care workers arrived varied and so they were not sure when to expect them. One person told us, "They don't turn up on time. I should get a call around 6:30pm and last night it was 9pm. Two weeks ago my 9am call was completed at 12pm." They added that they worried in case the care worker had been involved in an accident. In addition, people receiving care and care workers told us that some calls had been missed one person told us, "The other Sunday I was left without care."

Care workers told us and records showed that rotas did not consistently contain travel time between care calls. One care worker told us, "There is no travel time allowed, I have to leave [a care call] early." Another care worker said, "Sometimes travelling time is not built in and you have to work around it." In addition care workers and people using the service told us that a number of staff had recently left. Care workers said that it had impacted on the care people received as they felt pressured and rushed when more calls were fitted into their day. People had noticed this and one person told us, "They come and do what they can as quick as they can."

People told us that lack of care workers meant they did not always have the same care workers visiting them. They said the lack of consistency in care workers meant that care workers did not know what they were normally like and so would be less able to identify if they were unwell.

These shortfalls in providing care workers at the right time had increased the risk that people would not safely receive all of the care they needed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing.

Care plans clearly recorded whose responsibility it was to order, collect and administer medicines.

However, the provider was unable to assure us that people received their medicines safely. We identified a number of concerns relating to medicine administration records (MAR). We saw that they were handwritten by care workers and did not always record the strength and dosage of the medicine to be given. We saw that there were gaps in the MARs so it was not clear if medicine had been given appropriately and where medicine was recorded as being refused there was no recording of why the person refused their medicine.

Changes in medicine were not clearly recorded. For example, we saw that one person needed to take warfarin and their prescription had changed. Some notes were added on the MAR but it was not clear what dosage should be given. In addition, there were two different strength of tablets available but both were being recorded under the same entry on the MAR. We found that MAR contained errors, for example, we saw the signatures to show that one medicine had been crossed out. There was no recording on the MAR to say why this had been done and the provider had not identified it as an issue to discuss with care workers.

Care plans did not contain guidance to support care workers to administer medicines. For example, there were no care plans to advise when medicine prescribed to be taken as required was needed. In addition there was no information regarding the administration of creams to support care workers to know where it needed to be applied and how often.

People's care plans contained information regarding the environmental risks in their home and had identified their risks when care workers supported them to move. However, shortfalls in risk assessments meant that people were not fully protected against the risk of them being harmed through unsafe care and treatment. For example, we saw that there were no assessments in place when people needed care to prevent pressure sores and falls.

Accident records were stored in people's care plans but there was no indication that any changes in care had been put in place to keep people safe. There was no analysis of accidents to ensure that the same issues were not reoccurring.

These shortfalls meant that people were at risk of not receiving their medicines as prescribed and were at risk of being harmed by unsafe care. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment.

Recruitment of new care workers had not always been completed in line with the current legislation. While appropriate disclosure and barring checks had been

Requires improvement

Is the service safe?

completed the provider had not always ensure that they had received references for new care workers. This meant the provider was unable to assure themselves that care workers were reliable and trustworthy.

People at risk of harm were protected by care workers who knew what constituted harm and how to raise concerns. Prior to our inspection we had a number of concerns raised with us by care workers about the care people were receiving. This showed care workers knew how to raise concerns with external agencies and they told us that they could raise concerns with the manager. Care workers were supported by information it the staff handbook. However, when we spoke with the provider they were unsure of when it was appropriate to raise a safeguarding alert.

Care workers could tell us how they worked to reduce the risk of infection. For example, by using protective equipment and changing it after giving personal care. However, some people told us staff did not always wear their protective equipment when giving care. People also told us that equipment was not always disposed of appropriately. For example, Staff would leave used gloves in an open bin in the living room which the person told us they felt was unacceptable.

Care workers were aware that they were an infection control risk if they were ill and knew that they had to be symptom free for 48 hours before returning to work. One care worker told us that they were supported to follow this. However, other care workers told us they had been pressured to work by the provider while they had a stomach bug.

The provider had a brief infection control policy which did not fully support care workers to work effectively to reduce the risk of cross infection. For example, there was no guidance for care workers on how to dispose of used protective equipment.

Requires improvement

Is the service effective?

Our findings

Care workers did not receive effective training and support to ensure they had the skills and knowledge needed to provide safe care to people. People told us that some care workers had the skills to provide care but that new care workers were often not fully supported. One person said that they had problems when two new care workers came together as they did not have the skills needed to provide safe care.

The provider required new care workers to complete a training package in the form of learning booklets before they started working for the company. However, some care workers told us they felt unsupported completing the training at home in their own time as they had no one to answer any questions they had. In addition, care workers told us that while the training was helpful it did not fully support them with the practical skills needed to provide care. One care worker told us how they had to support a person with a colostomy bag and the person had to tell and show them what to do.

The provider told us new care workers shadowed an experienced member of staff to gain skills and confidence. However, care workers confirmed that this did not always happen. One care worker said, they worked with another person but it was not shadowing as the people visited needed support from two care workers. Another care worker said that they spent one evening with another carer to learn people's needs. Both these people confirmed that they had not previously worked in care and so had no experience to support them. Concerns were also raised by care workers that those asked to support new staff had not always been with the company long and had not always had their competencies checked by the provider.

The provider told us that there was a system in place to support care workers with spot checks, supervisions and annual appraisals. Three care workers confirmed that they had spot checks, but one told us they had worked independently before their competencies were checked. The manager told us that while some spot checks, supervisions and appraisals had been done they were not up to date and records relating to these had not always been filed in staff records. Therefore, it was not possible to identify how many had been completed and when care workers were next due a spot check. This meant that the provider could not be assured that care workers were competent in their work.

Shortfalls in training and supporting staff meant that provider could not be assured that staff had the skills to provide safe care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our inspection we had received information which highlighted that the provider had not respected a person's choice in relation to the care they wished to receive. We passed this information over to the local authority to ensure the person was safe. In discussions with the provider we found they lacked knowledge of the Mental Capacity Act 2005. For example, where a person was unable to make a decision the provider was not aware that the decision to administer covert medicine should be made in the person's best interest and should involve health care professionals and families. Covert Medicine is medicine hidden in people's food so they're not aware they are taking it.

Where people may not have the ability to make decisions, this was not consistently recorded in their care plans. For example, one person's care plan noted that they could make day to day decisions but struggled with more complex decisions and needs support. However, there was no recording of what support was needed or who helped them make complex decisions.

Records showed care workers had completed training in the Mental Capacity Act 2005 before starting work with the provider. Some care workers were able to explain how they offered people choices in their lives. For example, what clothes they wanted to wear. However, training was not always effective as some care workers told us that they were not aware of the mental capacity act.

Shortfalls in the provider's and care workers knowledge and implementation of the Mental Capacity Act 2005 Meant people's decisions were not always recorded. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people who received care were unable to eat safely and were fed directly into their stomach. While care workers had received training in using the equipment, there was no information in people's care plan about the

Requires improvement

Is the service effective?

care needed to ensure people were safe and equipment was properly maintained. There was also no recording that appropriate care of the feeding equipment had taken place. Information on the amount of food to be given was not clearly recorded in the care plans.

Care workers told us if they had concerns about people's food or fluid intake they would raise concerns with the office staff, who in turn would discuss with relatives and other healthcare professionals. Care workers said that if they had particular concerns them they would sit with a person while they ate. One care worker told us they were currently visiting a person who was not drinking much so they ensured that they had drank something before they left.

There were no care plans in place to show what help and support people needed to prepare and eat meals. There was no recording of what food the person preferred to eat. One person told us that some care workers did not have the required skills to prepare the food they wanted. They said that one care worker would do cheese on toast for them, but they had left and care workers supporting them now only used the microwave to heat food for them.

Care workers told us they would raise any concerns with the office who would then contact appropriate healthcare professionals. We saw this happen during our inspection and the office staff liaised with a relative to arrange a doctor's visit. Care workers told us they would also leave an entry in the care file about any concerns they had so that the next care worker to visit could monitor the person's needs. People using the service also told us that staff raised concerns appropriately. One person said, "If I'm not well they call the doctors."

Requires improvement

Is the service caring?

Our findings

Some people told us that the care workers were lovely and would do anything they wanted. One person said, "I look forward to them coming." Another person told us care workers were, "Marvellous and all very considerate." They also said that the care workers always checked to see if anything else needed doing.

Although people told us care was rushed they said that care workers were kind and gentle when giving care. One person told us, "They are caring and do everything they are supposed to do." Care workers we spoke with were able to tell us about people and their needs and how they preferred to receive their care. For example, one care worker told us how a person liked to be independent and do as much as possible for themselves.

Some people told us that care workers did not always stop to consider their impact in people's home. For example, one relative told us they had put the lid of the commode on the phone and felt that this was unacceptable. They also said that the provider was not considerate of their home environment. For example, the provider turned up expecting to be able to provide training to a number of care workers on the care a person needed at their home, without discussing it with them in advance. The provider said that if they were not allowed to train the quality of care would decrease and the person would have to go back to a care home. The relative told us this frightened the person.

People told us that care workers were rushed and did not stop to check if everything had been done correctly. For example, one person said that care workers would plug the hoist in but would not ensure it was switched on. This meant the person would be unable to get out of bed as the hoist was not charged.

The provider told us that when a person started to use the service they could state if they want a male carer or not. This was added to the computer system and it ensured that a male care worker was not allocated. The provider told us that they liked to try and keep people with the same care workers for consistency but this was not always possible due to sickness and holidays.

However, one person told us that while the care provided was adequate the care worker was not cheerful when they visited and the time spent with the care worker was not as positive. They had asked for an alternative carer, but were told by the provider that they were not able to choose a carer worker they wanted to support them as the provider was short of care workers. People told us that they did not receive a rota and therefore did not know what care worker was coming to support them or at what time to expect them. One person said, "We used to get a list of names but don't anymore."

People told us that the provider had gone through their care plan with them when they started to use the service and the care plans we reviewed had been signed by the person receiving care.

We identified some concerns around privacy and protecting confidentiality. For example, when we arrived at the service the receptionist was speaking to a person about their relative who care workers had raised concerns about following their morning visit. The receptionist was discussing if they or the relative should contact the doctor. This did not respect people's privacy.

Requires improvement

Is the service responsive?

Our findings

People told us they knew they could phone the office to complain. One person said, "If I am not happy I would phone the office but I have not had to do that." Another person told us, "I have no complaints and I am very grateful they are here."

The provider told us that individual complaints had been resolved. However, people told us that the provider was not responsive when they rang up to complain. One person said, "The provider steamrollered over everyone and it didn't get resolved." Another person who phoned the office as they had not received a call told us, "I phoned up and they said they hadn't got anyone to care for me. I can't get up on my own and the neighbour had to come in and help me. I phoned several times and they said they would get back to me and never did."

The provider did not monitor complaints and they were unable to tell us about any complaints they had received or changes they had made care to keep people safe. Information about complaints was stored in people's individual files. Therefore, the provider was unable to tell us how many complaints they had received or to do any trend analysis to see if the same complaints were reoccurring.

Shortfalls in the provider's management of complaints meant that complaints were not always fully investigated and lessons learnt were not always implemented. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Receiving and action on complaints.

Care plans did not always reflect people's needs and did not support care workers to provide person centred care. The member of office staff who reviewed care plans told us they were updated once a year or when people's needs changed. However, we found that care plans were not up to date and had not been reviewed when people's needs changed. For example, we saw one person needed more calls during the day after a stay in hospital. This was not recorded in the provider's care plans. A care worker told us, "I have raised concerns with the office as care plans are not up to date." Care workers told us that important changes, such as a change in medicines were recorded in the daily notes in capitals for other care workers to see. There was a reliance on local authority notes but these were not detailed enough to enable person centred care to be given. One care worker told us that they used the local authority information to see what care was needed.

In addition, some people who were receiving care as they were near the end of their lives did not have a provider care plan in place. We saw for one person, the only information the provider had was a one page document they had received when they agreed to take on the care. There were no risk assessments in place and no evidence that the person had been able to discuss their needs and personalise their care with the provider.

A care worker told us that if people's abilities deteriorated and it was taking longer to provide care they would contact the office. They told us they provider was good a liaising with the local authority to ensure that they had enough time to meet people's care needs.

Care workers told us if they were late they would ring the office and let them know so that other people who were waiting for care could be notified of a delay. However, people we spoke with told us that they were never informed if their care worker was going to be late.

We saw that some people had companionship calls. These were calls to support people's needs to access the community. However, there was no information recorded in the care plans about what people liked to do during these calls. One person told us "There are no plans."

Inadequate

Is the service well-led?

Our findings

We found that the provider was involved in the day to day practicalities of running the service and was reacting to concerns identified. This reduced their ability put systems in place to pro-actively manage and support care workers and to complete audits and quality checks to ensure people received a consistent service. Consequently the quality of the service provided to people was not maintained and people received poor care which did not meet their needs.

There was a new assistant manager in place. Their role was to ensure the office was organised and systems were in place to support high quality care. However, they had not previously worked in a care environment and so were not aware of what checks and audits were needed to identify poor care.

Care workers were unsupported and systems to monitor their competencies and identify training needs were not in place. The provider's reactions to concerns being raised were unsupportive and issues were not resolved. Some care workers told us that they were not supported by the provider and that they were unable to raise concerns as they were on a zero hour's contract and if they said anything their hours would be cut. One care worker told us, "There is not enough training and not enough care and if you complain they take your hours away."

While the provider told us that there were plans in place to support care workers through regular staff meetings, none had been held prior to our inspection. Updates to care workers were delivered in an unstructured manner and it was not possible to ascertain if care workers received all the messages.

People we spoke with told us that the systems in the office did not support them to receive good care. One person told us, "You don't know who is coming or when. If my regular carer comes it's ok, but when she is off I don't get a list in advance." A relative told us that the office staff did not always complete rotas to ensure that new care workers were supported and people received safe care.

The provider had contracted with a company to ensure they were supported to stay up to date with legislation in relation to employment and health and safety. However, we saw that policies in place to support care workers to provide safe care were inadequate. For example, the infection control policy did not support care workers to dispose of used protective equipment and the medicines management policy did not support them in accurate recording of medicines,

The registered manager did not have robust systems in place to manage staff information. For example, some interview forms and supervision forms were not available as the provider had taken them home and had not returned them to work.

People were not supported to give their views on the quality of care they received. The assistant manager had put a system in place two months before our inspection to contact six people a week to get feedback. However, the provider did not ensure that the staff member responsible understood the system, or follow up on the results which meant that only ten people had been contacted.

Systems to monitor daily records and medicine administration charts (MAR) were ineffective. Some MAR charts had been audited. However, concerns had not been identified and it was not possible to track what had or had not been audited as no record was kept of what MAR had been returned to the office and what was in people's homes.

In addition there was also no auditing of daily record sheets and it was impossible to track the care people received as sheets were not always completed sequentially and some sheets were not available in the care plan. There was no auditing by the provider to see if the care workers were arriving on time, and staying for and the agreed length of time.

Lack of checks to ensure that all calls are covered when the rota is completed. For example, care workers and visitors told us that one Sunday a whole wet of calls for one person had not been scheduled.

Shortfalls in the provider's systems to monitor the quality of service provided and to gather the views of people using the service left people at risk of receiving poor care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance.

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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: People were not supported by an adequate deployment of staff who had the skills and knowledge to care for people. Regulation 18 (1) (2)(a).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People were not protected against unsafe treatment risks to people were not identified and medicines were not managed safely. Regulation 12 (2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: People's rights were not protected as the provider did was not aware of their responsibilities under the Mental Capacity Act 2005 Regulation 11.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints How the regulation was not being met: People were not protected against the risks associated with unsafe or unsuitable care as the provider did not or monitor complaints. Regulation 16 (2).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People were not protected against the risks associated with unsafe or inadequate care as systems to assess, monitor and improve the quality of care and mitigate risks were ineffective. Complete and accurate records were not kept and people did not have their views sought on the quality of service they received. Regulation 17 (1) (2)(a)(b)(c)(e).

The enforcement action we took:
We issued a warning notice to tell the provider they needed to be meeting the legal requirements off the regulation by 31 December 2015.