React Homecare Ltd

React Homecare Ltd

Inspection report

Unit 3
Langley House Business Park, Wykeham
Scarborough
North Yorkshire
YO13 9QP

Tel: 01723282888

Date of inspection visit:
19 May 2021

Date of publication:
22 June 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
React Homecare is a domiciliary care service providing personal care to people across Scarborough and Richmond. The service was supporting 157 people at the time of our inspection, including those living with dementia, physical disability, older people, younger adults and people who misuse drugs and alcohol.

Not everyone who used the service received personal care. CQC (Care Quality Commission) only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The provider was aware of the need to develop their governance processes to ensure better oversight. However, this had not been embedded since the last inspection. Records and risk assessments did not always contain essential, up to date information and guidance for staff. Supporting documentation around medicines such as risk assessments and body maps for creams were not always in place, though, medicine administration was safe.

Some checks and audits were in place, but these were not robust or effective enough to identify issues found on inspection.

Care calls were not always timely and communication around late calls was inconsistent. People also told us they wanted to be informed which staff would be supporting them prior to the call. The registered manager was going to explore how to effectively communicate this to people.

People felt safe and confident in staff's ability to provide care and gave positive feedback. Staff demonstrated a commitment to their role as carers and spoke positively about the provider and the support they received.

One person told us "One of the ladies was absolutely wonderful and she stayed with Dad through the night when he was dying. She was unbelievable. Mum is very close to her and she checks to see how Mum is managing from time to time. She is dedicated to what she does. My daughter, Mum and I think she and the carers are absolutely wonderful."

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Rating at last inspection and update
The last time we inspected this service the provider was called Clarity Homecare Limited, this was a name change only and the premises and management team has not changed. The rating was requires

improvement (published 24 December 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating and intelligence around potential risk.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to governance at this inspection.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

React Homecare Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and two Experts by Experience who made telephone calls to people using the service and their families. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave a short period of notice of the inspection to ensure the registered manager would be in the office to support the inspection.

Inspection activity started on 19 May 2021 and ended on 28 May 2021. We visited the office location on 19 May 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, safeguarding, Healthwatch and other professionals who work with 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.
The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and seven relatives about their experience of the care provided. We spoke with seven members of staff including the registered manager who is also the nominated individual, a care manager and care assistants. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included ten people's care records and several medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including audit records, policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also spoke to three professionals who work alongside the service for feedback.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely

- Staff were not always provided with accurate and complete information about risks to people to prevent harm occurring.
- There was no risk assessment in place for one person who was at risk of developing pressure sores and staff had not been provided with clear guidance for preparing food for another person at risk of choking.
- The provider had failed to assess the risk of the spread of infection associated with some staff who had chosen not to be included in regular COVID-19 testing
- The registered manager had failed to carry out any analysis of incidents and accidents, to learn from these and improve the safety of the service. For example, where people were at risk as a result of their mental health needs.
- The provider had failed to assess the fire risks to people associated with the application of flammable paraffin-containing creams.
- The provider had failed to implement effective systems for recording the application of external medicines. Staff had not always documented where on the body external medications, such as creams, had been applied.

The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and improve the quality and safety of the services. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection, the provider has developed a COVID-19 risk assessment and is in the process of implementing this with all staff.

- Despite the shortfalls in record keeping, staff demonstrated a good working knowledge of people's care and support needs.
- Staff reported any concerns they had about people's safety on to a live system which was managed by staff working in the office.
- Staff recorded medicines administered on an electronic system which was monitored by care managers based in the office. This allowed for an immediate response to any missed medicines or medicine errors.

Systems and processes to safeguard people from the risk of abuse

- The provider had effective safeguarding systems in place. Staff had a good understanding of what to do to

make sure people were protected from harm or abuse. They had received appropriate and effective training in this topic area.

● One person told us, "I feel very safe indeed, because of the high calibre of the staff. I can tell that they have been well trained and are suitable for the role. They also seem keen to do a good job."

● People's care records did not always provide guidance to staff around how to manage specific safeguarding situations. The provider explained this was due to confidentiality and associated risk. They are now looking at ways to ensure this can be effectively documented.

● Allegations or concerns of abuse were reported to the relevant agencies.

Staffing and recruitment

● People told us call times can be inconsistent and whether this was communicated effectively varied.

● One person told us "Timings can be all over the place hence my asking the carer today who is coming tomorrow and when. It can be as early as 8am or as late as 11.30am. They will phone if held up sometimes."

● Staff feedback on travel time between calls varied depending on which area they worked. However, when issues were fed back to the staff in the office changes to calls were made where possible.

● The provider operated a safe recruitment process.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At the last inspection the provider had failed to have systems and processes to assess, monitor and improve quality and safety across the service. This was a breach of regulation 17 (good governance).

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

- Some systems were in place to monitor the quality and safety of the service provided. However, these were not always consistently reviewed and had not identified issues found on inspection around records.
- Not all staff had spot checks carried out within the time frames set by the provider, this included competency checks around medicines. Audits were in place, however there was no oversight to ensure that all records were checked in a timely and systematic way. This resulted in some records being checked multiple times in a month and other records not being checked for over six months.
- The provider was using an electronic rota system and staff were monitoring call times throughout the day. However, data around the calls was not reviewed to identify any patterns or themes around missed or late calls. The provider had plans to introduce governance processes in various areas including call times however, these had not yet been implemented.

The provider had failed to establish and effectively operate systems or processes. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate good governance.

The provider responded immediately during and after the inspection to ensure documentation was amended where issues were identified.

At the last inspection there was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009. Enough improvement had been made and the service was no longer in breach of regulation 18.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff spoke highly about the service and support they received. They felt able to contact care managers and the registered manager to raise any concerns and get support when they needed it. Staff told us "I can approach them about anything" and another said, "It's the best care company I've worked for."

● The culture of the staff team was positive and staff were proud to provide high quality care. One staff member told us, "It's like a little family unit, it's lovely how it works, I was made to feel so welcome, people adore them (the staff). I would be happy for my mum to receive care from (providers name)."

● One person said, "Mum has dementia and they do take their time with her, we were involved in her care plan and got what we asked for and we are really happy with it. They take time out to talk to her and treat her with dignity and respect. They always ask Mum how she would like things done and don't rush her as they know she can only move very slowly."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People and their relatives were regularly asked for feedback about their care through telephone reviews, surveys and questionnaires. Feedback had been used to meet people's preferences. However, the provider still felt unable to provide a rota of staff supporting people despite requests. The service were looking at ways this could effectively achieved.

● The service had good working relationships with other agencies involved in people's care, seeking support and making referrals when required.

● Staff meetings had been put on hold due to the COVID-19 pandemic, however, staff felt communication was good and feedback acted on.

● The provider was keen to ensure staff had career development opportunities within the service and staff were engaged with this. The provider was in the early stages of developing training packages to improve the outcomes for people and their families; developing more effective ways of working with others.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●The provider and leaders worked in a transparent way, communicating with people, relatives and other agencies where things went wrong.

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 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems or processes were established and operating effectively to assess, monitor and improve the quality and safety of the services provided. The provider had failed to assess, monitor and mitigate the risk relating to the health, safety and welfare of the service users and staff. The provider failed to maintain an accurate, complete and contemporaneous record related to people's care and treatment. Regulation 17 (1)(2)(a)(b)(c)