

White House Home Care Services Limited

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Inspection report

37 Gorsedale
Hull
North Humberside
HU7 4AU

Tel: 01482827902

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This comprehensive inspection carried out by one inspector, commenced on 3 September 2018 and ended on 6 September 2018.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and people with physical disabilities.

Not everyone using White House Care Services Ltd receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection 14 people were receiving a regulated activity.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, responsive and well-led to at least good. However, during this inspection, we found they continued to require improvement. This is the third consecutive time the service has been rated requires improvement.

At the last inspection, we found concerns with three areas in the service. These were recruitment processes, the planning of person-centred care and monitoring the quality of the service. Despite some improvements, we found the provider continued to be non-compliant in these areas.

Some steps had been taken by the provider to ensure their recruitment procedures ensured people employed were of good character and had the necessary skills and competence, to carry out their role. However, they failed to carry out any of these checks on the volunteer, who was managing the service whilst they were away from the service. We continued to find some gaps in staff recruitment files, including a missing reference for one staff member and a missing interview record for another.

People had care plans in place and task sheets, which provided information to staff about the things they required support with. The provider had made some improvement to these, since the last inspection about people's preferred routine and included some of their basic likes and dislikes. However, there was minimal information about people's life history and important information about people's health and communication needs were missing. Despite this, staff were able to tell us how they provided person-centred care and people confirmed this.

There was a quality monitoring system, which consisted of audits and checks in some areas, but these did

not always lead to improvement being made. There were no audits on care records or recruitment and staff files, which led to shortfalls in the above areas being unidentified by the provider. There was no system in place to collate and analyse people's views to improve the quality of people's experiences. Accidents and incidents were recorded, but action was not always taken to prevent similar incidents reoccurring. Some staff told us the manager was unapproachable and one person praised the care and support from staff, but told us they felt the service was not well-led.

People told us staff sought their consent verbally before providing care and support and staff were aware of the importance of this. However, there was no record of people signing consent to their care plans. Following the inspection, the registered manager showed us how they would record people's agreement to their care plan. Staff had awareness of the MCA, but there was no system for recording consent if people lacked capacity.

You can see what action we have asked the provider to take in response to the above concerns at the back of the full version of the report.

We also found further shortfalls, which the quality assurance system had failed to identify, including staff support. The registered manager did not provide recorded supervisions for staff. We made a recommendation on this.

The service had a small staff team, which was sufficient to meet the current needs of people who used the service. Staff were knowledgeable about safeguarding and how to recognise signs of abuse to protect people from harm.

Staff were equipped with the necessary skills to provide effective support. They supported people to manage their medicines safely, as well as supporting them to meet their nutritional needs and healthcare needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were supported to maintain their independence and their privacy and dignity were respected. People were complimentary about staff and said they were kind and caring.

There was a complaints procedure in place. None had been received and people told us they would know how to raise one if required.

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.

The provider did not always assure themselves of the good character, skill and competence of volunteers. There were some gaps in recruitment checks for staff.

People received their medicines safely.

People were safeguarded from the risk of abuse and staff were aware of how to report concerns.

Is the service effective?

Requires Improvement ●

The service was not always effective.

People's consent was obtained verbally, but there was no record of people signing consent to their support plans. Staff had awareness of the MCA, but there was no system for recording consent if people lacked capacity.

People were supported by staff who were knowledgeable about people's needs and supported them to meet their nutritional needs and access healthcare.

Staff were skilled and had received training to provide effective care and support.

Is the service caring?

Good ●

The service was caring.

Staff respected people's privacy and treated people with dignity and respect. Staff were aware of people's likes and dislikes and supported people in line with their preference.

Staff promoted people's independence and people described them as kind and caring.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Care plans were missing information about people's life histories, health and communication needs. Despite this, staff had awareness of this and could provide person-centred care.

People had access to the complaints procedure and told us they would know how to make a complaint if needed.

Is the service well-led?

The service was not always well-led.

Some systems were in place to improve the safety and quality of the service, but there were gaps in the system, so opportunity to drive improvement was missed. There was also no system for auditing care records or staff files and recruitment, which led to shortfalls.

Staff and people who used the services views were not collated and analysed to improve the quality of the service.

People had mixed views about the running of the service. Some staff felt communication and staff support could be improved, and the manager was not always approachable.

Requires Improvement 

White House Home Care Services 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 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 was a comprehensive inspection, carried out by one inspector. We gave the service 24 hours' notice because the location provides a domiciliary care service providing support to people in their own homes. We needed to be sure that someone would be available at the office. The registered manager and nominated individual told us they would be unavailable during the planned inspection, so we started the inspection that day to ensure their involvement. A volunteer was managing the service in their absence. For this report, we shall refer to them as the acting office manager.

Inspection activity started on 3 September 2018 and ended on 6 September 2018. We visited the office location on 3 September to see the registered manager and nominated individual. We visited on the 4 September to review care records and policies and procedures. Following the site visit, we spoke with people who used the service, their relatives and staff on the telephone.

Before the inspection we looked at information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually, to give some key information about the service, what the service does well and improvements they plan to make.

We looked at the notifications received from the service and reviewed all the intelligence CQC held, to help inform us about the level of risk for this service. We also contacted the local safeguarding team. The local authority told us they did not commission this service.

We looked at three people's care records and three medication administration records (MARs). We also

looked at a selection of documentation in relation to the management and running of the service. This included quality assurance audits, complaints, accident and incident records, recruitment information for two members of staff, staff training records and policies and procedures.

We spoke with one person who used the service and five relatives. We spoke with three members of staff, as well as the registered manager, nominated individual and acting office manager.

Is the service safe?

Our findings

The service was not consistently safe. During the last inspection, there were concerns regarding safe recruitment practices. There were gaps in pre-employment checks including references and people starting employment before DBS checks had taken place. A DBS check allows employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. There was also no record of staff interviews taking place.

At this inspection, we found, one member of staff only had one reference, rather than the two the provider requested before commencing employment. Another staff members interview record was missing. The service was temporarily being managed by a volunteer for a two-week period, who we have referred to as the acting office manager, for the purpose of this report. The provider and registered manager had not requested any references or completed a DBS check for them. There was no evidence they had checked they had the qualifications, competence, skills or experience necessary for the work to be performed by them. As a result, the provider and registered manager had failed to ensure robust recruitment procedures were in place and operated effectively.

This continued to be a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Despite this, people told us they felt safe and risks were minimised where possible. One relative told us, "It was clear staff were concerned about [person's name] safety." Staff could protect people from avoidable harm and abuse. They had good awareness of how to recognise and report any concerns. The provider followed the local safeguarding adults board safeguarding policy. There was a whistleblowing policy in place, but this lacked detail about who staff could report concerns to outside of their organisation. This was noted to the acting office manager so the provider could rectify this. Staff we spoke to knew how to report concerns and who they could report these to.

There were sufficient numbers of staff available. The registered manager told us they would not agree to provide more care if they did not have staff available to provide the care. During the inspection, agency staff were providing cover for staff who were on annual leave or sickness. People told us staff stayed for the allocated time and most said they were on time or would call if they were going to be late.

Most people managed their own medicines or were supported by family. Where it was identified people required support with this, staff supported them safely. Medicines were supplied by the pharmacy then administered and recorded on medication administration records (MAR's) by staff. A medicine label for one person did not match what was written on the MAR and there was no body chart in place for another person's cream, to show where this should be applied, despite the medication policy saying this was required. We checked these and found them to be minor recording errors, which the acting office manager agreed to address.

Risks in people's home environments were considered and recorded on a risk assessment. Risk assessments

were also completed for medicines and moving and handling. However, we found one person's medicine risk assessment was blank and another person's was missing. There was no system in place to identify these gaps in recording, which we have referred to in the well-led section.

Systems were in place to protect people from the spread of infection. Staff told us they were provided and used personal protective equipment (PPE); People and their relatives confirmed this.

Is the service effective?

Our findings

The service was not always effective. The registered manager did not provide and document a record of staff supervision. They told us they were in regular contact with staff and they supported staff regularly on an informal basis. However, two staff told us they did not feel supported. The registered manager and provider had put plans in place to provide staff with annual appraisals. However, we were unable to check this because they had not yet started this.

We have made a recommendation that the provider seeks advice and support on implementing an appropriate supervision process.

Staff were aware of the importance of gaining consent before providing support. Staff told us how they sought consent and people confirmed staff did this. Most people had arranged to receive a service for themselves and had given consent to the support verbally. However, there was no written documentation for people to sign consent to their care records. Following the inspection, the registered manager sent us a document showing us how they would record people's agreement to their care plan. There was no system to document how consent would be obtained where people may lack capacity. We refer to this in the well-led section.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Most people receiving a service had capacity. Staff had awareness of the MCA and could tell us about how they would apply this to ensure people were supported to make decisions.

People were supported by staff who had completed a range of training to equip them with the skills and abilities to carry out their roles effectively. Training was provided by the registered manager and provider, who had completed train the trainer training; this provided them with the skills to provide training to staff. Staff received an induction when they started in their role, which consisted of classroom based learning and shadowing the registered manager.

People were supported to maintain a diet of their choosing. We saw people were supported to prepare meals or staff prepared these on their behalf, where this was agreed in their care plan. A relative said, "We have used ready meals in the past, but now carers cook whatever [person's name] likes. Another person confirmed this, "Staff make whatever I want, if I have the ingredients." People's care records confirmed people were provided a varied and balanced diet, where people's choices were followed.

Staff could tell us how they would respond to certain situations and when they may need to seek medical advice. Staff liaised with health professionals, where needed and supported families to seek out medical advice. One relative told us the staff were very good at suggesting when their relative may need to get in contact with the GP on their relative's behalf. Staff and people told us staff worked in partnership with

health professionals in the community.

Is the service caring?

Our findings

The service was caring. Everyone we spoke to consistently spoke positively about the staff. One person told us, "Staff are all very nice."

Relatives we spoke to were very positive about the staff and the support they provided. Comments included, "Staff are ace. They are all good and I can't fault them." Another described the care as "exceptional". A third said, "It's very good. The carers are superb."

Staff were also positive about their role. One told us, "I love the job and I love caring."

Staff were kind and caring. A relative said, "There are the business types and caring types and they are the caring types."

People told us staff had a good approach and were friendly. A relative told us, "Staff are very affectionate and caring. I have spoken to them because I was concerned about [person's name] feeling down, but they are good at reassuring them." Staff were attentive to people's needs. One person told us about their relative who had poor vision and could be anxious. They said staff gave their relative a hug upon arriving and leaving, which provided them reassurance and demonstrated how they had built a trusting relationship.

Staff respected people's individual needs and encouraged them to make choices. A relative told us, "Staff give [person's name] choices and asks how they want their hair doing. Staff explain things as they are doing it."

Staff could tell us how they maintained people's dignity and respected their privacy. People and their relatives confirmed staff did this. Staff were also aware of the importance of maintaining confidentiality.

Staff promoted people's independence and encouraged people to maintain their skills and abilities. A member of staff said, "We encourage people to do as much as they can themselves." Staff could tell us about ways they positively encouraged people. For example, encouraging one person to walk from the bedroom to the bathroom to increase their mobility.

Staff recorded daily entries when supporting people. We found these showed staff took time to talk to people and provide reassurance, as well as checking if they needed anything else. A person told us, "If there is still time left, staff will do any extra jobs I need doing."

Staff were aware of equality and diversity and respected people's individual needs and circumstances. From speaking with staff, we could see people were receiving care and support which reflected their diverse needs.

Is the service responsive?

Our findings

The service was not always responsive. At the last inspection, the registered provider had not ensured assessments and plans of care included full information about how people's needs were to be met in the way they preferred. This meant staff may not have accurate and up to date information and there was a risk important care could be overlooked.

At this inspection, we found people's care plans contained some person-centred information about people's basic likes and dislikes. For example, their hobbies or what they liked to watch on television. Information had also been included about what people liked for breakfast and how they preferred their drinks. There was information which provided staff with guidance about what support people required and their preferred routines. Despite these improvements, there were still gaps in people's care plans about their health and how this impacted on them, as well as how they communicated. For example, there was no information about how one person's health condition meant some days they required more support than others and how their health condition affected them. For another person, information was absent about how their memory affected them. There was also no information about people's current circumstances or life history, which is important so staff can have meaningful conversations with people who may require support with their communication or memory. Due to the gaps in people's care plans we found there was still a risk important information could be overlooked.

A relative and staff informed us one person's care plan had been missing from their home for approximately one year. This meant staff did not have access to information about this person and the support they required. We told the acting office manager, who told us they would ensure a copy was returned to the person's home.

This continued to be a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was small and staff were familiar with people. They were knowledgeable about people's needs and preferred routines. Staff were aware of people's individual circumstances, likes and dislikes and provided person-centred care as a result. A relative said, "When staff come they know exactly how to care for [person name]."

People's needs were assessed before receiving a service. There was no evidence of when care plans had been reviewed or how people were involved in this. Despite this, most care plans were up to date and people felt they were able to discuss anything with the registered manager at any time. A relative told us, "Reviews seem to happen regularly when [provider and registered managers name] ask if everything is working." Another relative said, "They get in touch and ring to see if things are working. They are really good."

There was a complaints policy in place and people were provided this information when they received a service. The service had not received any complaints and people told us they knew how to make a

complaint. A relative said, "I would just ring them up and let them know. The impression is that it would be sorted out personally."

Is the service well-led?

Our findings

The service was not always well-led. At the last two inspections, we found areas of concern with the providers quality assurance systems. During the last inspection, they had failed to ensure systems were in place to assess the safety and quality of the service, identify shortfalls and drive improvement. Although there had been some improvements made throughout the last two inspections, these were insufficient to be compliant with regulation 17.

The acting office manager had been supporting the registered manager and nominated individual to implement an audit system. Checks had been carried out on areas including staff daily records, medication administration records (MARs) and accident and incident logs. Although these audits were being carried out, they did not always identify shortfalls and address these with an action plan to drive improvement. For example, despite accidents and incidents being monitored, the registered manager did not have a system in place to ensure appropriate action was taken following these, to prevent similar incidents reoccurring. Two people had falls recorded in the accident and incident folder. However, falls risk assessments had failed to be implemented following this. This meant the safety of the service had not improved.

There was no audit of people's care records which meant the provider failed to identify and address any gaps in these including information about people's communication and health needs. Consent had also not been recorded effectively, including how they had complied with the Mental Capacity Act 2005 (MCA). There was no record to monitor when care records should be reviewed. This would have helped to prevent one person's care plan being missing from their home for a substantial amount of time. There was also no audit of staff files, including checks of staff recruitment, training and support. This meant gaps in staff recruitment and supervision were missed and any opportunity to rectify these issues and drive improvement was lost.

The provider told us people could complete reviews of the service online, however there was no evidence people were provided with this information and the registered manager did not request stakeholder views formally, such as through surveys, so these could be collated, reviewed and action taken to drive improvement. The registered manager told us they regularly provided care to people and saw them on a regular basis, as well as working closely with staff, so they gained some of this information informally.

The registered manager and acting office manager had started to implement spot checks on an ad hoc basis to drive improvement in the quality of care staff provided. Although this was an improvement, there was no criteria for what they were monitoring. For example, if staff had the correct equipment.

The registered manager worked in partnership with other services and health professionals, but they did not always keep a record of communication they had, so outcomes for people could not always be followed. We noted this to the acting office manager, who agreed to log this.

This continued to be a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback about the registered manager. Some staff felt they were not approachable, whereas one staff member told us they had felt supported by them. One relative also felt the registered manager could be unapproachable.

There was a sense of team work amongst staff, although they did not all feel supported by the registered manager. A member of staff said, "I think the staff as at team work really well. We all do what we can to help and support each other. I just don't think we are looked after properly."

People who used the service and their relatives knew the names of the registered manager and director of the service. They knew how to contact them and most people told us they could get in touch with them or if they left a message someone would get back in touch with them. Staff told us they would receive updates and information from the registered manager either by text, phone call or when they went into the office to collect equipment.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The registered provider had not ensured plans of care included full information about people's needs and how they were to be met in the way they preferred. This meant staff may not have accurate and up to date information and there was a risk important care could be overlooked.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems and processes were not established or operated effectively to assess, monitor and improve the quality and safety of the service.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>Recruitment procedures were not operated effectively to ensure staff and volunteers were of good character and had the qualifications, competence and skills and experience required for their role.</p>