Homebased Care (UK) Limited

Homebased Care (UK) Ltd - Erdington

Inspection report

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Ratings

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

Overall summary

We undertook an announced inspection of Homebased Care – Erdington office on 2 and 19 February 2015. We told the provider that we were going to visit 48 hours before our visit on the first day and 24 hours' notice for the second day.

The service was last inspected over 3 days in January, February and March 2014. At that inspection we had determined that the service was not effective in monitoring the quality of the service, was not protecting people from the unsafe management of medicines, was not effective in the planning and delivery of care because suitable systems were not in place for obtaining and acting in accordance with people's consent. An action plan was sent following that inspection.

Summary of findings

At this inspection we saw that consent was obtained for the care provided however the other issues had not been fully addressed.

Homebased Care – Erdington provides care and support to people in their own homes. The service provided care for up to 300 people although this number could vary.

People's needs were assessed and they were involved in planning their care. People's needs were not always appropriately met because there were late and missed calls which resulted in people not receiving their meals and medicines at the required times.

Some people were not happy with the care and support they received. There were some systems in place to monitor the quality of the service but the systems were not effective in achieving improvements and maintaining any improvements made.

This meant that the law was not being met in respect meeting people's needs and of monitoring and assessing the quality of the service. You can see what we have asked the provider to take at the end of the report.

There was no registered manager in post at the time of our inspection. 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. However, an individual was in place managing the service.

People were not always protected from abuse and injury because although staff had the skills and knowledge to keep people safe; missed and late calls but their health and welfare at risk. Staff were knowledgeable about the actions to take in emergency situations but did not always put their knowledge into practice.

People did not always receive continuity of care because there were a large number of staff that supported them.

People's health was monitored and there was appropriate liaison with the healthcare professionals involved in people's care.

People had developed good relationships with their regular staff but did not always feel listened to or that their concerns were appropriately addressed by office staff.

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 always safe.

People felt safe with the staff that supported them and staff had and the skills and knowledge to keep people safe from abuse and harm.

People were sometimes not safe because they did not get the care and support they needed due to late and missed calls.

Inadequate

Is the service effective?
The service was not always effective.

People were not always provided with a service that met their needs effectively at the times they had agreed and that ensured that they received food and drink at regular times.

People were supported to make decisions about their care.

Requires improvement

Is the service caring?
The service was not always caring.

People were happy with their regular staff and had developed friendly relationships with them.

People were supported to make choices and their rights to dignity and privacy respected.

Requires improvement

Is the service responsive?
The service was not always responsive.

People were not always provided with care and support in a personalised way.

People were not always supported by the same staff so did not always receive continuity of care and calls were not always carried out at the times people wanted or had been agreed.

There were some systems in place to gather people's views but people did not always feel that their views were listened to and actions taken to address the issues raised.

Requires improvement

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

There was no registered manager in post but there was a structure in place to manage the service.

Staff felt supported and listened to but people were not always happy with the way in which office staff responded to their calls.

Requires improvement

Summary of findings

There were some systems in place to monitor the quality of the service provided but they had not ensured that continual improvement was achieved.

Homebased Care (UK) Ltd - Erdington

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 brought forward due to concerns we had received and 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 2 and 19 February 2015. We gave the provider 48 hours on the first day and 24 hours' notice on the second day as we needed to be sure that someone was available to assist us.

The inspection team consisted of two inspectors on both days and on the first day a specialist advisor who had skills in quality assessment processes accompanied the inspectors.

We reviewed all the other information we held about this service. This included notifications, safeguarding alerts and information from local authorities.

As part of our inspection we spoke with seven people who used the service and six relatives and six staff by telephone. During our office visits we looked at the care records of five people to check the care they received. We looked at the files of six staff to check the recruitment process, training and the support staff received from the organisation to carry out their work. We also looked at other records associated with the running of the service including staffing rosters, complaints records and quality monitoring checks.

Inadequate

Is the service safe?

Our findings

Information we had received from social workers and people that used the service before our inspection showed that there were missed calls and calls not at the agreed times. One person had had a missed night and morning call and when staff arrived for the lunch time call the person was found on the floor with injuries and needed hospital treatment. Another person had gone to bed without food and drink due to missed calls. A relative had provided us with evidence of missed and short calls. Managers told us that there had been a number of staff changes that had affected the service. This meant that people's needs were not always adequately met and their health and welfare put at risk. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.We found that the registered person had not always protected people adequately to have their needs met adequately and reflect their preferences. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from avoidable harm. People and relatives told us that they felt safe and comfortable with the regular staff that supported them. One person said, "Carers are good." A relative said, "Carers have the right language. This makes them [person receiving a service] feel safe." Staff spoken with told us and we saw that they had received training in how to keep people safe. Staff were knowledgeable about the different types of abuse and their responsibilities in raising any concerns they may come across. We saw that the appropriate actions were taken by the registered provider when concerns had been raised.

Actions were taken to identify and manage identified risks so that staff and people were protected from injury. People or their relatives told us that they had been involved in the risk assessment process. Staff told us that risk assessments were accessible in people's homes so that they were aware of the risks. Records we looked at showed that a variety of risk assessments were in place. These included risks due to the environment, health issues and equipment used. Management plans were in place to minimise identified risk. Staff told us and records confirmed that they had received training in areas such as moving people safely and using equipment such as hoists for people unable to stand up.

We asked staff what actions they would take in emergency situations such as not being able to gain access to the home of someone who received a service or if they were found to have fallen. All the staff told us that they would contact the office so that contact could be made with families and ring the ambulance if the person was injured. However, whilst looking at records in the office we saw that one person was not at home when the member of staff arrived at the home. We asked to see what actions had been taken in respect of this but there was no record that contact had been made with the office. The managers told us the staff had not contacted the office. This showed that although staff told us what they would do this was not always followed up in practice.

Seven people spoken with told us they had late or missed calls. One person said this was due to a shortage of staff and five felt it was due to poor management of staff and a lack of appropriate response from the office staff to staff absences. People felt that the staffing problems were worse during the weekends. One person told us, "The agency is short staffed, they don't cover sickness." Another person said, "Not enough staff, office don't take responsibility." People were concerned about the constant changes in staff. We were told that on occasions only one staff arrived to carry out a two staff call. We informed the provider about the comments we had received for them to address.

We had received two concerns that indicated that medication had not been given as prescribed, for example, not at the prescribed times. One relative told us that their family member had been upset as a dispersible tablet had been placed in a pot to be taken with another tablet that was not dispersible and staff were not aware of how to apply a prescribed cream. We looked at the medication records of three people and saw that people were not receiving their medicines as prescribed. For example, medicines to manage diabetes were sometimes given in the morning only or three times a day instead of twice a day as prescribed. A tablet to manage cholesterol One of the manager's present at the inspection confirmed told us that all the staff had had the appropriate training and didn't know why the instructions hadn't been followed.

Requires improvement

Is the service effective?

Our findings

All the people spoken with told us they were happy with the care and support they received from their regular staff but not from the replacement staff. One person told us that some of the replacement staff had not been satisfactory and lacked training. There had been a recent incident when two staff, both of who appeared not to be able to use a hoist and there was a near miss when they lifted them and nearly dropped them. However, records showed that staff had received training in areas such as administration of medicines, moving people safely and infection control. Records showed and staff confirmed that new staff worked alongside experienced staff before they attended calls themselves so that they got to know how people liked to be supported.

Most people we spoke with were not aware that checks were carried out on the quality of the care provided by staff. However, some people confirmed that there were occasional checks on the care staff provided. One person told us they were asked about the quality of the care provided. All the staff spoken with confirmed that senior staff carried out checks on their work and we saw records of these checks. During our office visit we were told that it was planned that each member of staff had at least one check a year. Staff confirmed and we saw records of individual meetings with staff to discuss work related issues and there were occasional staff meetings. This meant that there were some systems in place to support staff to be effective in their roles.

We found that the service was not always effective in providing people with continuity of care and support that met people's needs. This was because people were not always receiving care and support from regular staff. Most of the people spoken with said that they had a group of staff that could attend their calls. However, most people spoken with did not know which of the group were going to attend any of their calls and people said the service was worse at weekends. One person said, "There are a group of carers but we don't always know which will come." Another person said, "We have a group of carers but lots of different staff turn up. Having different carers every other day is not good."

People spoken with told us that staff usually stayed for the allotted amount of time however, some concerns we received before our inspection were about staff not staying for the required length of time. The information we received indicated that although all the tasks were carried out they were rushed.

The Mental Capacity Act 2005(MCA) sets out what must be done to make sure that the human rights of people who may lack capacity to make decisions are protected. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to the Local Authority for authority to deprive someone of their liberty. We saw that people's ability to make decisions about their care had been assessed. Where people did not have the ability to make decisions we saw that family members or other significant people were involved. All the people we spoke with told us that they or their relatives were involved in decision making about the care and support they received. One person told us, "Staff are aware of my likes and dislikes. I am in control." Another person told us, "Care is delivered in line with the care plan." Staff spoken told us they couldn't remember having training in how to support people who were not able to make decisions but thought they may have done. When prompted further staff were able to explain how they would know if people were agreeing to the care. For example, they would observe facial expressions to see if they were happy.

We saw that care plans identified where people needed support with food and drink. However, two people were concerned that they did not get the help and support needed with food and drink due to the late arrival of the staff and staff missing visits. One person said staff arrived to provide their breakfast at12 midday, and then arrived to provide the lunch time call an hour later. Another person said they went to bed without food and drink due to missed calls. One person said staff arrived to provide their breakfast at12 midday, and then arrived to provide the lunch time call an hour later. Another person said they went to bed without food and drink due to missed calls. This meant that people did not always receive food and drink at intervals that were spaced out during the day due to the organisation of calls.

We saw that people were supported by a number of healthcare professionals. Staff spoken with told us that they would inform office staff, if they felt an individual was unwell or call 999 if it was an emergency and then let the

Requires improvement

Is the service effective?

office and family members know. Care plans showed which healthcare professionals were involved with people with contact numbers so that they could be alerted if the need arose.

Requires improvement

Is the service caring?

Our findings

All the people spoken with told us that they were happy with their regular staff. One person said, “Regular carers are brilliant”. Two relatives said, “Happy with regular carers. One sings to [person] and she is happy” and “We have a good laugh [with staff].” Staff spoken with spoke about people in a caring and respectful way. However, One relative commented that staff talked over the person in the staff’s own language which was confusing to the individual and did not give them the opportunity to contribute to the decision. Some people commented that they did not feel that the office staff were caring. One person told us that they felt “let down” because, “They [office staff] don’t seem to care.” This was because they had experienced missed and late calls and had stopped raising concerns due to the lack of appropriate action by the office staff in the past.

People told us they were able to make decisions about the care and support they received and felt listened to by staff that supported them. Records showed that people had been involved in planning their care and staff were able to describe how they involved people in their care and ensured that they were happy with the care. One member of staff told us, “I would encourage them to let me support them but would record in the book and let the office know if they wouldn’t agree to the care.”

All the people spoken with told us that staff that supported them were polite and promoted their privacy and dignity. Staff spoken with were able to give good examples of how they maintained people’s privacy and dignity. This included ensuring doors and windows were closed, people were kept covered whenever possible when personal care was provided and leaving people to use the toilet in private. Maintaining people’s privacy and dignity was part of staff training showing that steps were taken to ensure staff were aware of the importance of maintaining people’s privacy and dignity.

Requires improvement

Is the service responsive?

Our findings

All the people we spoke with told us they had a care plan in their home and either they or their relatives had been involved in providing information about their needs. One person told us, "Yes I was fully involved." Before our inspection two people had raised concerns with us that they had experienced delays in getting care plans however, we saw copies of care plans in all the files we looked at during our office visit. Most people told us that staff delivered care according to their care plan. All the staff spoken with were knowledgeable about the needs of people they supported. One person told us, "Most staff do work to deliver care according to the care plan but some try to deliver care without bothering to read the care plan and so ask a lot of questions which can be annoying." We saw that people were matched up with staff with specific skills such as Asian languages so that their needs were met in a personalised way.

People told us that their needs were reviewed on an annual basis or earlier if needed. One member of staff told us, "We monitor all the time as circumstances change all the time." Records we looked at showed that care plans were updated as and when required.

Most people felt they were not kept informed of staff changes or if staff were going to be late. One person said, "They [staff] come when they feel like it. We are not informed of delays. They [office staff] don't think this is a problem." One person told us that they were unable to have a lie in during the mornings because this was the only time the staff could fit their call in. Although the person had agreed to have the call at that time staff sometimes did not even attend at the arranged time and could be very late. This showed that the service was not responsive to their needs. People told us that they had a team of staff that could attend to support them but they didn't know who would be attending. During our office visit we discussed with managers people's comments and that the service should consider how the deployment of staff could promote continuity of care for people.

Since our last inspection in March 2014 we had received 15 concerns of which 12 raised issues of missed, late and short calls. During conversations with people and their relatives six had commented on late, early or missed calls. Late or missed calls can mean that people's dietary and medical needs were not met on time and some people said they were left emotionally upset. One person told us, "Time keeping is appalling. They [staff] come when they feel like it." Another person told us, "Timing is not consistent. Delays are frequent. Last weekend an evening call was 8.30pm instead of 9-9.30pm and the following day the morning call was at 9am instead of 8am. There were four or five missed calls in January." Records we looked at showed that visits were not always made at the planned times so that people's needs were not being met in a personalised way.

We asked eleven people if they would know what to do if they were unhappy with the service. Everyone told us they would ring the office to raise their concerns but were not aware of the process or what to do if they wanted to escalate an issue. Four people told us they had not raised any concerns and two people told us their concerns had been dealt with appropriately. Five people told us either they had raised concerns and were not happy with the response or did not feel there was any point in raising concerns. Comments included; "Response is inadequate. Agency is full of excuses blaming staff for what is clearly incompetence by the care company", "it is pointless, office don't care" and "Office never seem interested or caring. It feels like you are constantly fobbed off." Staff told us they would make the office aware of any concerns raised with them if they couldn't be addressed by them straight away.

Requires improvement

Is the service well-led?

Our findings

There was no registered manager in post at the time of our inspection and we had not received notification of the absence of the registered. However, at the time of writing this report an application to register a manager had been received by us.

At the time of our inspection the manager from another branch of the agency was supporting Homebased Care - Erdington. In addition, the director and quality monitoring manager was present to support the management of the service. Care co-ordinators were involved in the day to day management and support of staff providing care to people. All the staff spoken with told us that they felt supported by the care co-ordinators and the quality monitoring manager. This showed there was a management structure in place to organise and monitor care packages however the service was not well managed and monitored as evidenced by the number of missed, late and short calls. A number of concerns relating to missed, late and short calls had been raised with commissioners of the service for Birmingham and Solihull Local Authorities. Commissioners were working with the agency to improve the service. We found that the registered person had not protected people against the risk of receiving inadequate care and mitigating risks due to ineffective systems and processes to assess, monitor and improve the quality of the service. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives that used the service did not always feel listened to. Some people we had spoken with and people who had contact us with concerns about the service told us there were communication problems between families and the agency. One person told us, The provider doesn't seem to care about the people who receive a service." Another person told us the office staff did not return calls when they had been promised and another person said that when they raised issues they were made to feel that it was there fault. This meant that people did not always feel that there was an open and inclusive culture that encouraged people to raise concerns.

People we spoke with expressed a variety of views about the quality of the service provided. Some people were happy and some people were not. Six of the thirteen comments were not complimentary about the service. One person said, "Haven't got a bad word to say about the carers. Service is brilliant." A second person said, "Service is okay, not brilliant" and a third person said, "Company not well organised, frustrated by the number of changes of carer. They don't seem to know where carers are at any given time" and "They don't seem all that organised."

We saw that there were some systems in place to gather the views of people. For example, there were occasional telephone calls to people; surveys were sent out so that they could be completed anonymously and complaints were monitored. We saw that there was a complaints log which included a record of the complaint and action taken in response however; some of the concerns raised by people had not been recorded so that there was not an accurate assessment of the levels of dissatisfaction of people that used the service.

Management meetings were held on a weekly basis to raise and identify shortfalls in the service and agree action plans. However, these systems had not resulted in developing a quality service where people could be assured that they would receive care and support from regular carers and the times agreed so that their needs were met appropriately. A service user group was set up to provide people with an opportunity where people could raise dissatisfaction about the service as well as contribute to the strategic growth and development of the business. The first meeting of this group was held on 23 January 2015.

There was an audit system in place to monitor calls by checking a sample of communication books when they were brought into the office. We looked at a sample of books but could see no evidence that issues were being identified and actions taken in response. We were told that these issues were raised in staff meetings but there was no evidence that issues had been followed up with individual staff or additional monitoring put in place so issues could be addressed. Spot checks were carried out to establish whether staff were attending people's homes as scheduled. Staff confirmed that these did take place and they were unannounced. There was a plan for each staff member to be spot checked a minimum of once per year.

The provider told us that they had introduced an electronic system to plan calls and a call monitoring system so that

Requires improvement

Is the service well-led?

they would be alerted in real time to problems of late or missed calls. There were some teething problems which were being sorted out. It was planned for the electronic systems to be fully functioning by the end of March 2015.

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 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: People were not protected against the risks of receiving care or support that ensured their welfare and safety due to missed or short calls. Regulation 9(1)(a)(b)(c); 9(2); 9(3)(a)(b)(h) and (i).

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People were not protected from risks of inappropriate or unsafe care because there were not effective systems in place to regularly assess, monitor and improve the service provided. Regulation 17(1)(2)(a)(b)(e) and (f)

The enforcement action we took:
Warning notice