

Independence Homes Limited

Independence Homes Domiciliary Care Agency

Inspection report

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Date of inspection visit: 7 October 2015

Date of publication: 17/02/2016

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?

Good 

Is the service well-led?

Good 

Overall summary

Independence Homes Domiciliary Care Agency provides support for adults with epilepsy and people who have both physical and learning disabilities. They provide care to people who live in nine houses and require substantial support from domiciliary care workers. This support ranges from a few hours per day to 24 hour care.

The inspection took place on the 7 October 2015 and was unannounced due to concerns that we had received.

The service had a registered manager. 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. The registered manager and provider is the same person for Independence Homes Domiciliary Care Agency. On

Summary of findings

the day of our inspection we were supported by the Operations Director and two Senior Operations Managers and told by them that the registered manager had little involvement in the day to day running of the service. We were told the registered manager was also the provider and their main involvement was supporting the development of clinical best practice in the care of people with epilepsy.

There were good systems and processes in place to keep people safe. Assessments of risk had been undertaken and there were clear instructions for staff on what action to take in order to mitigate them. Staff knew how to recognise the potential signs of abuse and what action to take to keep people safe. However managers at the individual locations did not always report incidents to the local authority or CQC in a timely manner.

The operations team made sure there were enough staff to meet people's needs. However when the provider employed new staff at the service they had not always followed safe recruitment practices. The Operations Director sent us information to show how this had been rectified.

Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. We found that people had person centred care plans that were detailed and enabled staff to provide the individual care people needed.

Some people told us they were involved in the care plans and were consulted about their care to ensure wishes and preferences were met. Other people and relatives said they had not been involved in care planning.

Staff worked with both internal and external healthcare professionals to obtain specialist advice about people's care and treatment for seizures. The internal staff are coordinated by the registered manager who is a neurologist to provide governance in the management of seizures in epilepsy. However we received feedback from some external professionals to say that they were not always provided with information in a timely manner.

The provider had arrangements in place for the safe administration of medicines. We were told by staff that people were supported to receive their medicine when they needed it. People were supported to maintain good health and had assistance to access to health care services when needed.

We could not find evidence that the service considered people's capacity using the Mental Capacity Act 2005 (MCA) as guidance. People's capacity to make decisions had not always been assessed. People did not have choice to receive care from a different provider at the accommodation they lived at. DOLs applications had not always been submitted for those people who needed permanent support and to live at the address for their own safety.

People are supported to shop for, cook and prepare food and drink of their choice within their ability.

There were clear lines of accountability. The service had leadership and direction from the operation management team. However people and relatives were not aware of who the registered manager was and they were not visible on a day to day basis within the service settings.

Staff felt fully supported by operations management to undertake their roles. Staff were given training updates, supervision and development opportunities. For example staff were offered to undertake additional training and development courses to increase their understanding of the needs of people using the service.

Feedback was sought by the operational management via surveys which were sent to people and their relatives. Survey results were positive and any issues identified acted upon.

People and relatives we spoke with were aware of how to make a complaint and felt they would have no problem raising any issues.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

There were processes in place to ensure people were protected from the risk of abuse and staff were aware of safeguarding procedures. However incidents were not always reported in a timely manner.

Assessments were undertaken of risks to people who used the service and staff. We saw that appropriate action was taken in response to incidents to maintain the safety of people who used the service.

People were supported to receive their medicines safely.

There were appropriate staffing levels to meet the needs of people who used the service.

Requires improvement



Is the service effective?

The service was not always effective.

People's rights were not always protected in relation to making decisions about their care and treatment. Staff had an understanding of the Mental Capacity Act 2005 and acted accordingly.

Staff had the skills and knowledge to meet people's needs. Staff received regular training to ensure they had up to date information to undertake their roles and responsibilities.

People were supported at mealtimes to access food and drink of their choice in their homes.

Requires improvement



Is the service caring?

The service was caring.

People who used the service told us the care staff were caring and friendly.

People were involved in making decisions about their care and the support they received

People's privacy and dignity were respected and their independence was promoted.

Good



Is the service responsive?

The service was responsive.

Assessments were undertaken and care plans developed to identify people's health and support needs.

Good



Summary of findings

There was a system in place to manage complaints and comments. People felt able to make complaints and that complaints would be listened to and acted on.

Staff were aware of people's preferences and how best to meet those needs.

Is the service well-led?

The service was well led.

Staff were supported by the operations management not the registered manager as the registered manager did not have day to day involvement of the individual houses.

There was open communication within the staff team and staff felt comfortable discussing any concerns with their line manager.

People felt supported by the operations management team. People said that managers of some of the houses where care was provided were approachable and helpful.

The operations staff and quality team carried out regular audits to monitor the quality of the service and make improvements.

Good



Independence Homes Domiciliary Care Agency

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.

The inspection took place on the 7 October 2015 and was unannounced. The inspection team consisted of three inspectors. Two inspectors attended onsite visit and the third inspector contacted people and relatives by phone for feedback.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR) because we carried out the inspection sooner than planned. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we checked the information that we held about the service and the service provider. This

included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with eleven people and five relatives who use the service, four care staff, one co-ordinator, and two operations directors. We observed staff working in the office dealing with issues and speaking with people who used the service over the telephone.

We reviewed a range of records about people's care and how the service was managed. These included the care records for seven people, medicine administration record (MAR) sheets, six staff training records, support and employment records, quality assurance audits, incident reports and records relating to the management of the service. We spoke with two health care professionals after the inspection to gain their views of the service.

This was the first inspection of this service since its location had changed in February 2015.

Is the service safe?

Our findings

People we spoke with told us they felt safe using the service. One person said "I don't think about it. I'm safe I know". One relative told us "My daughter has very challenging behaviour and they do keep her as safe as possible." However other relatives told us that they did not always feel their loved one was kept as safe as possible.

People were protected from the risk of abuse because staff understood how to identify and report it. Staff had access to guidance to help them identify abuse and respond in line with the policy and procedures if it occurred. They told us they had received training in keeping people safe from abuse and this was confirmed in the staff training records. One staff member told us "I would let my manager know if I saw something. I'd whistle blow if I had to, but I'm sure I wouldn't here". Another staff member said "I think not looking after someone properly and not knowing about them is abuse, not just the more obvious stuff."

Staff described the sequence of actions they would follow if they suspected abuse was taking place. They said they would have no hesitation in reporting abuse and were confident that management would act on their concerns. Staff were also aware of the whistle blowing policy and when to take concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively. Staff could therefore protect people by identifying and acting on safeguarding concerns quickly.

However we found that the provider had not always submitted timely notifications to the care quality commission regarding safeguarding or incidents/ accidents that were ongoing or had been identified. We were given copies of the providers safeguarding audits and noted that six incidents that had been reported to local authorities had not been notified to CQC.

The registered person did not notify the commission in a timely manner of incidents that are reportable. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Recruitment procedures were not always robust to ensure that only suitable staff were employed. Records showed that staff had not completed a full explanation as to their employment history on application forms. Written references from previous employers were not always robust for some staff. We saw evidence that on three staff

members' application only one reference had been received. Other staff files showed that references were from friend's only not previous employment. Checks had been made with the Disclosure and Barring Service (DBS) before employing any new member of staff. The head of recruiting said that they only usually ask for the past 5 years' worth of work history. Everything is done electronically as well as the references. The Operations director addressed this immediately and wrote to us to state "We now hold full employment history for every member of staff."

We looked at the electronic rotas and saw there were sufficient numbers of staff employed to ensure visits were covered and to keep people safe. Staffing levels were determined by the number of people using the service and their needs. Staffing levels could be adjusted according to the needs of people using the service and we saw that the number of staff supporting a person could be increased if required. One member of staff told us "Yes, there are definitely enough staff. We can use bank staff if necessary to cover shifts so there's always cover." People and relatives we spoke to had mixed opinions on staff levels; one relative said "There have been a lot of changes recently. There have been a lot of new people coming in and lots of agency staff; changes in managers too. It's meant I've had to keep repeating myself all the time to make sure something is done. But it seems to be getting back on track now though." Another relative said "It does vary from day to day but I think yes, on the whole, it's fine."

Individual risk assessments were reviewed and updated to provide guidance and support for care staff to provide safe care in people's homes. Risk assessments identified the level of risks and the measures taken to minimise risk. These covered a range of possible risks such as nutrition, skin integrity, falls and mobility and seizures. For example, where there was a risk to a person having a seizure, clear measures were in place on how to ensure risks were minimalised. These included for staff to ensure pathways around the home were clear and that people were supported with hourly checks. We saw evidence these hourly checks had been happening. Staff could tell us the measures required to maintain safety for people in their homes. One member of staff told us, "People always take risks but we have to balance I suppose between keeping people safe and not restricting them." Another staff member told us "I look after one person who has no

Is the service safe?

concept of money. We don't want to prevent them spending their own money but we can't allow them just to give it away. So we try to manage it by giving smaller amounts. I explained it to them and its fine."

People were supported to receive their medicines safely. We saw policies and procedures had been drawn up by the provider to ensure medicines was managed and administered safely. Staff were able to describe how they

completed the medication administration records (MAR) and the process they would undertake. Staff received a detailed medicines competency assessment on a regular basis. We looked at completed assessments which were found to be comprehensive to ensure staff were safely administering or prompting medication. Audits on medicine administration records (MAR) were completed on a monthly basis to ensure they had be completed correctly.

Is the service effective?

Our findings

People and relatives we spoke to felt they had a choice in their daily care. One person said "I do what I want. I go out on my own and do things for myself". Another person said "I can make those decisions for myself. No problem." One relative told us "My relative needs quite a lot of care and can't make a lot of decisions for themselves safely. But the staff don't take away all the decision making. She can still make small decisions."

We saw conflicting evidence in people's person centered plans (PCP) that their mental capacity had been assessed in relation to making specific decisions for example; where they live or choosing the care they receive or how they received it. The PCP had generic statements under the heading mental capacity assessment tool as to whether a person had capacity to make certain decisions for their care. For example; visiting the dentist and taking medicines. These documents had been completed by staff making assumptions about the person's capacity. There was no documentation to show that an individual capacity assessment had been undertaken for the different decisions or what format the assessment had taken, e.g; written, pictorial dependent on people's communication needs.

PCPs contained no evidence of people's lasting power of attorney or an other legally responsible person or Deputies appointed by the Court of Protection for making decisions. Some people who had been deemed not to have capacity had been asked to sign tenancy agreements and consent to care forms.

DoLS ensure that people receive the care and treatment they need in the least restrictive manner. Some people who were being potentially deprived of their liberty such as having wheelchair restraints or, bedrails in place had not had capacity assessments or DoLS assessments undertaken. There was a lack of evidence of best interest meetings or involvement from an independent mental capacity advocate to support decisions had been made in the person's best interest.

Where people did not have the capacity to consent, the provider was not acting in accordance to legal requirements. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked relatives about issues of consent and whether they were involved in decisions concerning people's mental capacity. A relative told us, "My son needs a lot of one-to-one support. Staff come to me if big decisions need making. Having said that, they allow them to make what decisions they can, like what to wear or eat". Another relative said, "The staff keep me informed if there's any change in my relative's mental state. Staff are really good at understanding she has some days where she's better than others".

We asked staff about issues of consent and about their understanding of the Mental Capacity Act (MCA) (2005). The staff we spoke with told us they had undertaken training in this area. All of the staff members we spoke with had a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Staff could give us a broad overview of Deprivation of Liberty Safeguards (DoLS) for the people they were supporting. DoLS is part of the MCA. The purpose of DoLS is to ensure that someone, in this case living in a supported living home, is only deprived of their liberty in a safe and appropriate way. This is done when it is in the best interests of the person, has been agreed by families and professionals and there is no other way to safely care for them. One staff member told us, "I think it's really about acting in people's best interests. People are allowed to take risks and we would only do something if they didn't understand the risks they were taking". Another staff member told us, "I think it's about making sure people are safe because they are at risk". A third staff member said, "DoLS is about us making decisions for people but only if they can't for themselves". So although the staff understood what needed to be done on a daily basis people's capacity to make big decisions about their lives had not been considered in line with legislation.

People and relative we spoke to thought staff had enough skills and experience to carry out their role. One person said "I have no problem at all. The staff seem very knowledgeable about epilepsy and how to manage it".

Staff received induction and regular training. We spoke with staff about their experiences of induction. One staff member told us, "I had a two week induction. I got a chance to shadow staff at that time and get used to working here. I could ask any questions I wanted and felt very supported."

Is the service effective?

We saw records that all staff attended classroom training which was undertaken at the head office. No external trainers are used unless they have a specific need for example with peg feeding or Makaton training. New staff are undertaking the care certificate with a view at some point to existing staff doing it. Staff we spoke to confirmed regular training was undertaken. Staff we spoke with were satisfied with the training opportunities on offer. One staff member said, "It's really good. We have training offered by the home and outside. I have an NVQ 4." Another staff member told us, "It's very good and it's relevant to the people we are supporting." A third staff member said, "Yes, that's okay. I've learned a lot".

Staff had regular supervisions and a planned annual appraisal. These meetings gave them an opportunity to discuss how they felt they were getting on and any development needs required. The staff we spoke with were happy with the supervision and appraisal process. One staff member said, "I have a one-to-one with my manager every two weeks. I can say what I like really". Another staff member told us, "It's part of working here". A third staff member said, "I can approach my manager at any time I suppose but supervision is good." Staff had contact

regularly with their manager in the office or via a phone call to receive support and guidance about their work and to discuss training and development needs. This was to ensure that the quality of care being delivered was in line with best practice and reflected the person's care plan. This also helped staff if they wanted to discuss any concerns or ideas they had. Staff said they found these to be beneficial.

People were encouraged and supported to be involved in the planning and preparation of their meals and supported to be independent where possible. People's level of support varied in each of the different home settings. Some people undertook their own shopping and cooking and some people require full support with planning, purchasing and cooking their food.

We were told by people using the service and their relatives that most of their health care appointments and health care needs were co-ordinated by staff. Staff were available to support people to access healthcare appointments if needed and liaised with health and social care professionals involved in their care if their health or support needs changed.

Is the service caring?

Our findings

People and their relatives told us the staff were caring and listened to their opinions and choices.

One person said, "I like them (staff). They are so easy to get on with." Another person told us, "I wouldn't want to live anywhere else." A third person said, "I like all the staff." A relative told us, "Well there is no problem there. All the staff seem very kind. They are absolutely brilliant." Another relative said, "I can't fault the staff. They are great."

Relatives we spoke with told us they were happy with the service and thought the staff were caring. One relative told us, "Oh yes, and no doubt. My relative has no problem there". Another relative said, "The staff are so caring and respectful. That's one of the first things I noticed".

Independence Home domiciliary care agency provides personal care to people in nine different sized buildings. Each person who lives in the nine houses has different levels of needs and abilities. All of the buildings are staffed 24 hours per day. One person said to us "The staff have helped me come back from a dark place that I couldn't get out of. They're brilliant and sometimes they give me a kick up the arse (!) when I need it." Another person said "Nobody tries to stop me doing what I want to do."

People were involved in decisions about their care and support at care plan reviews and meetings with care staff.

People were able to express their views via feedback surveys which gave them an opportunity to express their opinions and ideas regarding the service. One person said "I fill in a questionnaire."

Staff were respectful of people's privacy and maintained their dignity. Staff told us they gave people privacy whilst they undertook aspects of personal care, but ensured they were nearby to maintain the person's safety. Staff all spoke on how they promoted people's independence.

The registered manager and staff had a good understanding of people's specific care needs. During the inspection visit they told us they were committed to provide a good service. People's care planning records were written in a person centred way. They helped staff understand a person's life history, their likes and dislikes, based upon the person's wishes as to what information they wanted to share. This information was available in people's homes so staff had access to it. Comments from staff included, "It really is a good help so you know if there are any issues which might upset the person."

Staff told us how they assisted people to remain independent and said if a person wants to do things for themselves for as long as possible then their job was to ensure that happened. One staff member described, when someone can't manage to dress themselves any more without support we encourage them to do as much as they can. One person said "I do what I want. I go out on my own and do things for myself."

Is the service responsive?

Our findings

We asked staff what they understood by the term 'person centred care'. All of the staff we spoke with displayed a good understanding. They were able to describe to us in detail the process of providing care that revolves around, and includes at every stage, the person receiving it.

One staff member told us, "I think it really means that the person you're looking after is the centre of things". Another staff member said, "It's helping people to live independently I think."

Records we viewed and discussions with the Operations Director and Senior Operations Managers demonstrated a full assessment of people's needs had been carried out before people had moved into the service. Care records contained information about people's initial assessments, risk assessments and correspondence from other health care professionals.

People's care and support plans were developed with the involvement of people using the service. People said that when their care was planned and assessed before they moved to the service. This included what level of care was required and how individual specialist needs were going to be met and delivered. We saw person centred plans that comprehensively described the support people would need when they experience seizures, people's physical needs such as other health conditions and their physical limitations. These support plans contained information on medicines and their side effects, sleeping patterns and cognitive ability and nutrition.

Person centred plans (PCP) we looked at had been regularly reviewed and updated to ensure they accurately reflected people's current care needs. They were live documents that were open to change. People's care plans

detailed how their needs changed if they became physically unwell. Systems were in place to help ensure staff had access to the most up to date information about the people they supported. If anything of note occurred there were good communication systems in place to contact the senior on-call team, 24 hours per day.

Staff supported people to access the community which reduced the risk of people being socially isolated. Daily records called daily PCP Delivery plans recorded the care and support people had received and described how people spent their days. For example plans detailed when a person was supported to have bath, or was supported to go out. This included activities they had been involved in and any visitors they had received.

The provider promoted involvement from people in person centred activities. They had a specific programme called FOCUS that supports people to learn, be included, maintain independence and develop social interactions. The programme included opportunity such as Wheelchair and Limited Mobility sports, pamper sessions, rock climbing and social evening such as film nights and pub nights. People said about activities they had taken part in. One person told us how they had "Great Fun" at the Brands Hatch Petrol Head track day event. Another person said "It was fantastic, I never thought I would get the chance to go racing. I had the best day."

People were actively encouraged to give their views and raise concerns or complaints. The services saw concerns and complaints as part of driving improvement. People's feedback was valued and people felt that the responses to the matters they raised were dealt with in an open, transparent and honest way. We saw evidence of individual complaints and the logged resolution for them. This identified action undertaken by the provider, which showed they were actively driving improvements.

Is the service well-led?

Our findings

Staff showed an understanding of the vision and values of the service. We asked the question, “What is the purpose of the service and what does it offer to people?” One staff member said, “Each service user is an individual like all of us. We are here to cater for their individual needs”. Another staff member told us, “I think it’s to help people have a good a life as possible.”

The service had a registered manager who was also the registered provider and they did not have a day to day involvement of running the individual houses. They had delegated this responsibility to the operational management team.

The service had systems in place to monitor the quality and effectiveness of the service. These included visits by the operations director. The operations manager told us information collected during the visits was used to identify any issues. The house managers undertook a six month service review based on SWOT analysis. This is an assessment of strengths, weakness, opportunities and threats.

The service also involved family members in quality checking the service provided. We saw the family quality checker reports for three of the separate houses. Questions that were asked included Happiness of the person, Provision of activities, Interaction between support team and person. The responses were all positive. Comments included “From the moment I walked in, I thought they

were a well trained professional unit.” Another comment stated “The manager appeared to have a comprehensive knowledge of people and actively encouraged their personal development.”

Other quality assurance checks from the provider included details of areas that had been identified where improvement could be made. For example; One person had not been assigned a keyworker within the allocated time. The manager had identified the deficit and allocated a staff member and date to fulfil this role.

The auditing process provided opportunities to measure the performance of the service. Internal audits measured the effectiveness of the service against a number of regulatory frameworks including HSCA Regulations 2014 and RIDDOR reporting for health and safety. The registered manager had systems in place to identify, assess and manage risks to the health, safety and welfare of the people who used the service.

Staff said they felt they would be taken seriously by the operations manager. Staff told us they had been supported through their employment and were guided and enabled to fulfil their roles and responsibilities in a safe and effective manner. Team meetings were held regularly which included for example discussions about new people moving to the service, checking paperwork and effective handovers.

People’s and relatives views about the service they received had recently been sought. Most all of the comments were positive.

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

Personal care

Regulation

Regulation 18 CQC (Registration) Regulations 2009

Notification of other incidents

The registered person did not notify the commission in a timely manner of incidents that are reportable.

Regulated activity

Personal care

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Where people did not have the capacity to consent, the provider had not undertaken the appropriate assessments.