Care Quality Commission

Independent People Homecare Limited

Independent People Homecare

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Independent People Homecare is a domiciliary care agency providing support to people in their own home. The service provides live-in care support and care calls in the community. At the time of inspection, they were providing support to 73 people.

Not everyone who used the service received personal care. CQC 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
We received mixed feedback about the service. Generally, people were happy with the support they received from their regular live-in care workers. However, they were less satisfied when relief care workers were in place.

In addition to providing live-in care workers to people, the provider was delivering a community service where staff supported people with calls for short periods throughout the day, to help them with personal care or medication.

The registered manager and provider did not follow their policy to promptly notify the local authority of service failure. Leading to people going without their required care calls and placing them at risk of neglect. We found the registered manager and provider had not escalated potential safeguarding concerns to the relevant local authorities to investigate.

Risk assessments did not always contain all the information needed to support people safely. Where risk assessments were in place we found processes put in place to mitigate risks were not always followed.

Medication was not always managed safely, when care calls had been missed, we could not be assured people had received their medicines as prescribed.

We were not assured that the provider learnt lessons when things went wrong. The provider had identified the need to implement an electronic call monitoring system following an episode of calls being missed. However, at the time of inspection this had not been implemented.

The provider needed to improve the governance systems they had in place to ensure effective oversight of all aspects of the service. Monitoring of safeguarding and financial records needed to improve.

Staff received supervision and were supported with training in person and on-line to equip them with the skills they needed to support people.

People were mostly satisfied with the support they received with eating and drinking from their regular live-in care staff. People were supported to access other healthcare services such as GPs.

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. We did find that some best interest decisions needed to be more detailed and less generic.

People were more positive about the care they received from care workers who supported them consistently in comparison to relief care workers. Care plans reflected people needs in a person-centred way. However, some relatives told us when care plans were reviewed they did not always contain accurate details.

The provider and registered manager had systems in place to manage complaints, however they did not always escalate concerns to the appropriate safeguarding authority when complaints were related to poor care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service at the previous premises was Inadequate (report published 9 December 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made. We have identified breaches in relation to safeguarding, safe care and treatment and good governance. This is because safeguarding concerns were not always raised and responded to promptly, medication was not always managed safely, learning was not implemented from previous failures, and governance systems were not safely underpinning the service.

This service has been in Special Measures since 9 December 2020. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
The inspection was prompted in part due to concerns received about people going without calls, missed medication, staff not being trained, lack of PPE and staff not having disclosure and barring checks. A decision was made for us to inspect and examine those risks. Additionally, notification of a specific incident prompted the inspection. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

We have found evidence that the provider needs to make improvements. Please see the full report. 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Full information about CQC's regulatory response to the more serious concerns found during inspections is

added to reports after any representations and appeals have been concluded.

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? The service was not safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our effective findings below	**Good**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Requires Improvement**

Care Quality Commission

Independent People Homecare

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of three inspectors and an expert by experience. 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 Care Quality Commission. 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 the provider notice of the inspection so that inspectors and the expert by experience could begin to make telephone calls to people and staff before inspectors attended the providers offices. Inspection activity started on 22 September 2021 and ended on 27 September 2021. We visited the office location on 27 September.

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 and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report.

During the inspection
We spoke with fifteen people and their relatives about their experience of the care provided. We spoke with nineteen members of staff including the provider, registered manager, deputy manager, consultant, training manager, live-in care manager and support workers.

We reviewed a range of records. This included seven people's care records. We looked at eleven staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including training records, policies and procedures were reviewed.

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 inadequate. At this inspection this key question has now changed to requires improvement. 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.

Systems and processes to safeguard people from the risk of abuse

At our last inspection systems and procedures in place were not robust enough to demonstrate people were protected from risk of harm, potential abuse or neglect. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

- The registered manager and provider failed to follow their own systems and policies to safeguard people.
- There was a failure by the registered manager and provider to promptly notify the local authority of a potential risk of service failure to people over a weekend. Due to this failure people who were being cared for in the community went without care calls, placing them at risk of neglect.
- The provider and registered manager did not have adequate systems in place for senior staff acting as the main point of contact to follow in this situation to prevent people being placed at risk.
- We found serious complaints that had been raised by people or their relatives had not been referred to the local authority safeguarding team for an independent investigation and review. Due to this we could not be assured that people were safe or protected.

This is a continued breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Risk assessments were in place but did not always contain all the information needed to support people appropriately. For example, we found one person required an ankle brace to mobilise however this had not been detailed in their moving and handling risk assessment.
- A risk assessment for a person receiving support with their medication did not include one of the medications they required support with.
- For people requiring support with their finances we saw financial risk assessments had been completed.

Part of this risk assessment was to keep records and receipts for money spent, we found no records had been kept. This was against the providers policy of keeping receipts and checking peoples finances.
● The provider had not implemented an electronic system to monitor missed or late calls. We could not be assured the system they relied on was effective as missed calls had been identified in May, June and September placing people at risk of not receiving the support they needed.

Using medicines safely
●Two people were not supported with their medication over a period of a weekend due to missed calls. This placed them at serious risk of harm due to not receiving their prescribed medication.
● The provider completed their own investigation however there was no information given on what action was taken when it was identified medication had been missed, such as contacting peoples GP or 111 for advice.
● A relative told us, "The relieve carer had been given no training on how to administer insulin." The relative told us they had to complete this training with them.

Learning lessons when things go wrong
● The provider had not implemented lessons learned when things went wrong. When calls had been missed previously, as part of the providers lessons learnt they had identified they needed to implement an electronic call monitoring system. This had not been implemented and no other effective safety measures had been put in place, leading to further missed calls.

The above was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staffing and recruitment
● The provider told us they had continued to try and recruit staff and had put together attractive renumeration packages that were competitive within the market to try and attract new staff. However they had continued to find recruitment difficult leading to shortages with staff to provide care and support to people.
● The provider was completing the appropriate recruitment checks for new staff. Including obtaining an up to date work history, references and disclosure and barring check.

Preventing and controlling infection
● Staff were following national guidance to prevent and reduce the risk of infection.
● Staff told us they had received training on infection control and COVID 19.
● Staff were provided with all the personal protective equipment (PPE) they needed.
● Staff were supported to complete regular PCR tests to protect themselves and the people they were supporting. One member of staff told us, "We have loads of PPE, they send it weekly, we have gloves, aprons and gel. I test every week and I have had both doses of vaccines."

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to good. This meant people's outcomes were good, and people's feedback confirmed this.

Staff support: induction, training, skills and experience

At the previous inspection the provider was in breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to not being able to demonstrate staff had received sufficient training.

● The provider employed two training managers at the service to provide and oversee training. In addition to this the provider had supported field supervisors to be upskilled with 'train the trainer' qualifications so that they could also directly train staff.
● Staff underwent a full days training face to face when they first started, this was complimented by on-line training models. One of the training managers told us they supported staff to complete their training and if they needed assistance and support with the on-line training, they could support them with further one to one session.
● Competency assessments were in place for staff to evidence they had the skills to support people with medication and moving and handling. The training manager told us if required they could assess staff's competency in the community whilst they worked with people or the field supervisors could do this.
● Staff we spoke with all told us they had completed their mandatory training. One member of staff said, "My induction was very good, and I have completed all the training."
● Staff were regularly contacted via telephone to offer support and discuss their current placements. This gave staff an opportunity to express if they had any issues or needed any further support.

Supporting people to eat and drink enough to maintain a balanced diet

At the previous inspection the provider was in breach of regulation 14 (Meeting Nutritional and Hydration Needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the provider was no longer in breach.

● We received mixed feedback from people and relatives about how they were supported to maintain a balanced diet. One member of staff said, "I have frequently gone in to find [person name] with a glass in front of them that is too full so they cannot lift it to have a drink."
● One relative told us, "The food is good, and home cooked the staff have adapted to [person's name] preferred tastes and choices." A person told us, "The food is okay, I choose what I eat." Another relative said, "The relief carer was not good at cooking and it was mostly ready meals."
● Where people needed support with eating and drinking this was recorded in their care documentation.

● The registered manager had put together meal planners and recipes to help support staff when planning meals with people.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We saw examples in care documentation that people's needs had been assessed and were person centred to their specific needs.

Supporting people to live healthier lives, access healthcare services and support
● People's health needs were assessed and if these needs changed, we saw evidence that other health professionals were involved such as, occupational therapist and district nurses.
● A relative told us, "If there is a need the carer will call the family or if urgent, a health care professional e.g. the G.P. or District Nurse." Another relative told us, "[staff name] is very good at observing [relative name] and will pick up on things and relay to the family sorting out simple things but if the doctor was needed, would inform the family, but if they can't get hold of us would arrange direct with the G.P."

Ensuring consent to care and treatment in line with law and guidance
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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.
● From care documentation we saw consent had been obtained from people or their advocate for their care. However where best interest decisions were in place these needed to be less generic.
● Where lasting powers of attorney were in place, copies were held of these.
● Staff had received training in MCAs and DoLS.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
● We received mixed feedback about the support people received. Where people had regular live-in care support the feedback was very positive. However, they were less positive when relief care workers were provided whilst the regular care support workers were on leave.
● One person told us, "[The staff] are very caring and look after me well." A relative told us, "The main carer is excellent, we have no worries at all." Another relative said, "The main carers are great and will go the extra mile and we have had the same three main carers for over three years now."
● In comparison one relative said, "The quality of care is down to the individual carers and not always consistent. The skill of the carer dictates the amount of activities and visits out and whether there is a sense of calm or panic." Another relative said, "[person name] likes to eat with other people, it is a cultural thing, but the carer won't eat with them or even keep them company while they eat. We have mentioned this to the office, but it is always skirted over."
● Some relatives told us they were unhappy about the change over procedures from regular carers to relief carers. One relative said, "The profile sheet on staff the agency send is to brief and not enough detail on it. They send it through very late sometimes the day before, so no chance to do anything." Another relative said, "Change over is always a stressful time as we don't know who is coming until a couple of days before. The information we are sent is not always accurate and generic. It is implied if we are unhappy there is no one else."

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence
● We received negative feedback from a healthcare professional who told us a person's choice of whether received care from a male or female member of care staff was frequently disregarded even when they raised a complaint about this.
● Staff told us how they supported people and respected their privacy and dignity. One member of staff said, "I make sure when clients have visits from family and friends that I make tea but then I give them some privacy. Treating people with respect is about good manners and treating others how you would expect others to treat you."
● Another member of staff told us how they supported a person to have their home adapted to aid their independence. They told us, "I supported [person name] to have grab rails fitted and got a chair for them to use in the bathroom. We have a good relationship, I even googled how to reset their grandfather clock and they love to listen to it chiming now. [person name] said I have helped them put their home back in order."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to ensure the needs and preferences of people were met. This was a breach of regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

● The service had not always been able to meet the needs of people and provide staff to attend care calls in the community.
● Care plans we reviewed were mostly person centred and contained a good level of detail of how to support people.
● People and relatives, we spoke with told us that when they first starting using the service, they were involved in planning care needs. However, we received negative feedback about care plan reviews. One relative said, "We had a review about two months ago over the phone, when the care plan was sent for us to sign there were so many errors, we refused to sign it." Another relative said, "This week we had a care plan review, but it was full of errors and not accurate. The power of Attorney was wrong and [person name] had never smoked and none of the mistakes had been corrected."
● The registered manager told us they were currently doing care plans reviews and were working through between five and ten a month to update with people the support they required.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● We saw care plans included communication needs and support people required to be able to communicate.
● The registered manager showed us visual cards they had in place to help support people to communicate.

Improving care quality in response to complaints or concerns
● The provider had a complaints procedure in place for people and relatives to raise concerns.
● We saw evidence that complaints were investigated and responded to by the provider. However, we also found that where some complaints should have been escalated to a safeguarding investigation which had not been done.

End of life care and support

● At the time of inspection there was no end of life care being provided.

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 inadequate. At this inspection this key question has changed to requires improvement. This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the service did not have an effective quality assurance system from which issues could be identified and rectified to evidence continuous improvement. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider had made changes in management roles at the service. There was a new registered manager appointed and a consultant to advise and assist the service to make improvements.
● We found improvements still needed to be made and embedded into the service. As previously identified in the safe section of the report. The provider failed to take steps to immediately alert the local authority of service failure during a weekend in September where there were insufficient staff to provide care calls placing people at risk.
● There was a delay in notifying the CQC of service failure to carryout regulated activity to people. The provider has now handed back care packages to the local authority and has taken the decision that they will no longer provide the community aspect of their service and will focus on providing live-in care support.
● We found that complaints that had been raised to the service about poor care experienced by people had not been escalated to the local authority safeguarding team to investigate.
● The provider had been sub-contracting work to another agency to provide support calls to people. Although the provider had work profiles of agency staff, they had not checked they had the correct specialist training when needed to support people, for example with stoma care. The provider could not be assured people always received the support they needed.
● We saw little evidence of audits being completed, for example there was no evidence that financial audits of people's money were being completed, when staff were supporting them with finances.
● We found lessons learned had not been implemented at the service when things go wrong. For example, learning from care package failure previously had not been implemented to prevent this from happening again.

The provider and registered manager failed to have good governance systems in place. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● The provider told us they had spent time looking at the culture of the service and were actively addressing issues they had identified.
● There was documented evidence that the provider was engaging with staff and people. We saw evidence of frequent phone calls to staff to check their placements were going as planned and they had everything they needed, such as PPE.
● We had mixed feedback from relatives and people some saying that communication with the office was good and others saying the felt communication was poor.
● One relative told us, "We have had two visits from the care co-ordinator and they always chat with [person name] separately so they can speak out if they need to." Another relative said, "The office is available but mostly their involvement is a bit generic though the regional manager comes for most changeovers and occasionally for a scheduled check."
● In contrast one relative said, "We get the obligatory monthly phone call but it's so generic and nothing happens even when issues are raised."
● The registered manager told us they had developed new handover sheets to help with handovers between the live-in care workers. They were also developing a 'You said, we did' form to show how they would respond to concerns or suggestions raised by people, relatives or staff.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments did not always contain all the information needed to mitigate risks and provide support. Lessons learned had not been implemented to ensure future risks were mitigated.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes to safeguard people were not being followed placing people at risk.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider needed to improve governance and oversight at the service to improve outcomes for people.