React Homecare Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
React Homecare is a domiciliary care agency, providing personal care to people in their own homes. At the time of inspection, 24 people were using the service. 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
Not enough staff were deployed to meet people's needs in a timely way. People frequently had their care provided earlier or later than agreed which affected their daily routines. The provider did not resolve people's concerns over the timings of their care calls.

The provider was unable to confirm all care workers had received the required training to ensure their practice was up to date.

The provider did not ensure people received a personalised service and continuity of care. Significant numbers of different care workers delivered people's care due to the lack of regular staff. Preferences for a specific gender of care worker people requested were not always met.

Care records showed that some people's needs and risks had not been reviewed for over six months.

Shortfalls in the quality of the service that were already known to the provider had not been acted upon, and there was no plan in place to the make the improvements needed.

Staff were kind and caring and recruited safely. People's medicines and nutrition and hydration needs were safely met.

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

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

Rating at last inspection
This service was registered with us on 3 February 2022 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the arrangements of care and management of the service. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this 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 monitor the service and will take further action if needed.

We have identified breaches in relation to staffing levels, staff training and personalised care at this inspection.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

React Homecare Ltd

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector 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 houses and flats.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 6 April 2022 and ended on 8 June 2022. We visited the location's office on 6 April 2022 and 6 May 2022. We contacted people and their relatives on 8 April and 11 May 2022.

What we did before inspection
We reviewed information we had received about the service since it was first registered with the CQC.

During the inspection

We spoke with four people who used the service and five relatives. We spoke with nine members of staff including the registered and operations manager, two coordinators and five care workers. We reviewed a range of records. This included four care records. We looked at two staff files in relation to recruitment and a variety of records relating to the management of the service and policies and procedures.

After the inspection
We sought further information following the inspection including additional training records.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated 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.

Staffing

- Not enough staff were deployed to meet people's needs in a timely way. The provider told us they committed to delivering care to people no earlier or later than 30 minutes of the agreed time. However, records we reviewed and feedback from people, relatives and staff confirmed people regularly received their care more than 30 minutes earlier or later than agreed. This meant people were not always assure when they care would be delivered.
- We reviewed the data for five people's care calls for the six weeks prior to the inspection who between them had received a total of 691 calls. We found a 153 or 22% of these calls were delivered more than 30 minutes earlier or later than planned. On one occasion a person's bed time call was delivered more than 2 hours later than planned and another person's morning call was delivered 1 hour and 52 minutes later than planned.
- The majority of people and relatives we spoke with were not satisfied with the inconsistencies in their call times. One person told us, "They [React] are in chaos." A relative said, "Call times are all over the place, you get different carers all the time. As soon as you start to become familiar with those carers they disappear and a new lot start."
- A staff member told us, "My rotas change from day to day, and at short notice because of the staffing issues. I never actually know where I am going, and when I do, they regularly change part way through the day. People tell me they are fed up."
- People's preference for a specific gender of care worker was not always provided. One person told us, "I have told them I prefer female carers only for personal care. They still sometimes send male carers and when I rang the office once they said, 'we haven't got anyone else we can send.' A relative told us, "I have asked the office if they can send particular carers as [family member] responds to them, but it's like talking to a brick wall, it rarely happens."

We found no evidence that people had been harmed. However, the shortfalls in the deployment and arrangements in staffing placed people at risk of harm. This was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment

- Safe recruitment practices were followed. Pre employment checks had been carried out such as identity checks, right to work checks, and disclosure and barring (DBS) checks. DBS checks are background checks to check if staff are suitable to work with vulnerable people.

Assessing risk, safety monitoring and management

● Whilst risks to people had been assessed they had not all been reviewed following a takeover from the previous provider over six months ago. This meant there was a risk people's care and support would not be delivered in line with their current needs and risks. The registered manager told us they were still in the process of reviewing every person's needs and risks.
● Whilst staff had access to people's care plans and risk assessments, we were not assured the information was reflective of people's current needs due to the lapse in reviews of their support. This meant staff may not always have had access to people's current needs and risks.
● Plans of care and associated risk assessments for people we reviewed were detailed. Risk assessments included, but were not limited to, moving and handling, skin integrity, nutrition and hydration and environmental risks.

Using medicines safely
● All of the people we spoke with told us their medicines were managed safely and were administered at each care call. However, due to call times not always being met one relative told us they were continually anxious medicines may not be administered on time.
● We spoke to the registered manager who told us they recognised this concern and had discussed this with the relative adjusting their morning call time to ensure the person's prescribed medicines would be administered as prescribed.
● Electronic medicine administration records (MAR) were completed by staff after each medicine was administered. The system alerted staff and managers if any medicines had not been administered so action could be taken.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe. Feedback we received was positive about staff safely supporting people. One person told us, "I have three calls a day and I feel very safe." A relative told us, "Two members of my family receive care and support from React Homecare, and I feel they are both safe."
● Staff had received training in safeguarding procedures and were able to describe signs of when people may have been subjected to abuse. One staff told us, "If I noticed a bruise that was unexplained, I would report this to managers."
● The provider had systems and protocols to safeguard people from abuse. They notified CQC and other agencies as required.

Preventing and controlling infection
● People and relatives told us staff continually wore the appropriate personal protective equipment (PPE) during the COVID-19 pandemic.
● Staff told us supplies of PPE were adequate and they knew the increased risks to people due to the COVID-19 pandemic.
● The provider had a robust infection prevention and control policy in place and staff had received training in infection control.

Learning lessons when things go wrong
● No serious incidents had occurred, but processes were in place for the reporting and following up of any accidents or incidents.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- We were not assured all staff had received the required training. When we looked at staff who had delivered care in the six weeks prior to the inspection, 18 did not appear on the provider's training records. The registered manager told us staff from another service, who were providing care did not appear on training records for this service.
- Training records we did receive for 13 staff confirmed 11 had received no continence training, 8 had received no health and safety training, and one staff had not received any training.
- Records also showed some staff needed refresher training. For example, we identified eight staff whose medicines training had expired.
- When we further queried training records with the registered manager on the 8 June 2022 they did not know what training all staff had received.
- Furthermore, no training had been arranged to ensure gaps in staff training would be addressed.

Whilst we found no evidence of harm, the provider was unable to provide assurances all staff had received the required training. Systems and processes to ensure oversight of staff training were not in place. This placed people at risk of harm. This was a breach of regulation 18 (2) [Staffing] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Notwithstanding the shortfalls we identified with staff training, people and relatives reported no concerns relating to the competency of staff when delivering their care and support.

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

- All of the people we spoke with told us their nutrition and hydration needs were met.
- Where required staff supported people to prepare meals and drinks of their choice. One person told us, "They [Staff] prepare the meals we ask them to." Another person said, "I asked the carer who came yesterday to make an omelette. It was very nice; they are a fantastic cook!"

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff worked with other agencies and health and social care professionals to promote better outcomes for people. This included making appropriate and timely referrals to district nurses. A staff member we spoke with told us they contacted the district nursing team for consideration of additional support when they identified a concern with one person's skin integrity.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People had their care needs and preferences assessed and identified before any care was agreed and delivered. We saw detailed assessments which were used to inform care plans devised to support people.

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 MCA 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.

● At the time of our inspection there was no one having their liberty deprived. People's capacity to make decisions was assessed when planning care and support. People's relatives were involved in decision making where appropriate.
● Mental capacity assessments had been completed. People and relatives confirmed staff always asked for consent before providing care.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. 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; Respecting and promoting people's privacy, dignity and independence

- People and relatives we spoke with expressed their concerns and frustration of how they were treated and supported by the provider. They told us their daily routines were impacted by the irregular timings of their care calls. People said the sporadic timing of the calls meant their mealtimes and getting up and going to bed changed from day to day.
- Furthermore, people reported their dissatisfaction with the number of different care workers who supported them. Records we reviewed for the previous 6 weeks to the inspection corroborated people's feedback and confirmed one person had received care from 25 different care workers, another 24 and a further person 19.
- People and their relatives confirmed our findings. One person told us, "You get anybody, now and again you may get the same person." Another person told us, "I have about 8 or 9 different ones." A relative commented, "We don't get the same carers. Some of them come from the north of the country because they can't get local staff. You get used to one lot of carers and then they [React] swap them over again."
- We reviewed records for the previous 6 weeks to the inspection. They corroborated people's feedback regarding the high number of different care workers who delivered care.
- Whilst staff confirmed they had access to care plans, some expressed concerns over the lack of information contained within them. One said, "There is not always information within the 'app' for new people." Another said, "The care tasks required for me to complete were not always there."

The provider did not always ensure care and treatment met people's needs and preferences. People's daily lives were negatively affected by the lack of continuity of care. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives told us that staff were kind and caring. One person told us, "I can't fault them." Another said, "They are all kind."

Supporting people to express their views and be involved in making decisions about their care

- People and their relatives when required, were involved in the planning of care. However, people' views and decisions of how they wished for their care to be provided could not always be met due to the shortfalls in the arrangements of care we identified at the inspection.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Several people and relatives told us the service did not always respond or act when they contacted the office to raise a concern. For example, one person told us, "I had to ring the office as my carer hadn't turned at 9am. They told me they wouldn't be here until 10.30am. I've told them before, but nothing changes. It just seems so unorganised." Another person told us, "I ring the office with a concern and whoever picks up isn't very helpful."
- We reviewed the providers complaints policy. Section 4.4 of the policy states, 'React Homecare understands it can be difficult to separate a complaint from a concern, therefore, React Homecare will follow the policy when any dissatisfaction arises with the service'. The policy also states in section 5.4, 'complaints raised by phone will be logged'. Complaints records did not include the feedback we received from people which meant the provider did not always follow their own policy.
- The provider did not always provide personalised care to people. Whilst most people said they were happy with their care, the inconsistent call times and lack of regular staff meant their needs and preferences were not routinely met. One member of staff told us, "We support people who we [staff] don't know well and they [people] don't know us. There used to be a 'meet and greet' but it doesn't happen anymore."
- Some people told us they did not have access to their care plans. One person told us, "No I don't." Another person told us, "I don't think so." The registered manager told us copies were available to people electronically and they could log into an 'app' where they could view them. People's feedback suggested not all were aware of this facility or did not have the equipment to do this.
- Plans of people's care considered their physical, mental and emotional and social needs. People's life histories, interests and aspirations were recorded.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were assessed and recorded in their plans of care.

End of life care and support

- No one was receiving end of life care at the time of the inspection. Care plans included people's end of life wishes for people who had chosen to discuss them.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- People did not always receive personalised care due to the shortfall in the number of staff deployed. Call times were frequently earlier or later than 30 minutes of the agreed time. This affected people's daily routines and quality of life.
- The provider could not always provide people with continuity of care. They deployed staff from a sister service due to the lack of local staff. This led to people receiving care from a large number of different care workers.
- Most people and relatives felt the service was not managed well. When concerns were raised they said these were not taken seriously and little or no action was taken. One person described the service as 'in chaos'. A relative told us, "The service has no stability or continuity. When we contact them they don't resolve anything."
- Two staff members corroborated people's and relatives experiences regarding how the service was managed. One told us, "There is no routine for people, our rotas change at the last minute and it's not a good experience working here. When I raised my concerns recently a senior member of staff said, 'just do your best'." Another staff member said, "We don't know people well and they don't know us [staff]."
- Records were not always up to date. Not all care plans and risk assessments had been reviewed frequently. The provider was still using some of the previous provider's information and records despite providing care to these people for over 6 months.
- Training records were incomplete identifying some staff had not received all the required training. Several staff had not received refresher training in line with the providers timeframe. This meant staff may not be up to date with current practice.
- A further six packages of care were commissioned between the first and second day of the inspection with no additional staff recruited during this period. This was despite assurances from the registered manager on the first day of the inspection no packages of care would be commissioned until additional staff had been recruited which had not been.
- Not all staff felt supported in their roles. When they raised concerns these were not always taken seriously or acted upon satisfactorily.
- Known shortfalls we identified at this inspection were at risk of continuing or deteriorating further because plans were not in place to make the required improvements.

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

● The management team were aware of and had systems in place to ensure compliance with duty of candour responsibilities. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Working in partnership with others

● Where required the service worked in partnership with GP's and other health professionals.

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 9 HSCA RA Regulations 2014 Person-centred care People's needs and preferences were not always met.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Not enough staff were deployed to meet service users needs in a timely way. Assurances over which staff had received training were unclear. Some training had expired.

The enforcement action we took:

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