Locala Homecare Limited

Beckside Court

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

Summary of findings

Overall summary

Beckside Court, known as Locala Homecare, is a domiciliary care agency. It provides personal care to people living in their own houses in the community. It provides a service to older adults, including people living with long term conditions including frailty and dementia, who require ongoing support, support after a discharge from hospital and short term support while waiting for another provider. At the time of this inspection, 89 people were being supported by the service and were in receipt of the regulated activity, 'personal care'.

People's experience of using this service:

- People and their relatives told us staff were caring and provided a service that made them feel safe, promoted their independence and had a positive impact in their lives.
- We found that the service had deteriorated in some domains since our last inspection. However, the domains relating to caring and effective have remained the same.
- The service met the characteristics of requires improvement in three out of the five key questions.
- We found two breaches of the regulations. One breach in relation to good governance because of lack of consistency in the quality of records relating risks to people's care, support required and their consent. Management's oversight has not always been robust in how risks to people and medicines were managed by the service. We found a second breach because the provider failed to notify the CQC of safeguarding incidents.
- The management of risks was not always consistent. We found known risks to people's care were not always identified in their risk assessments.
- Medicines were not always managed safely. The provider had identified in their internal audits that this was an area that required improvement and actions were being taken to address the issues. We made a recommendation about medicines.
- The provider had several systems in place to monitor the quality of the service but their effectiveness was not always consistent. The provider had identified some areas that required improvement however, other areas such as the recording and monitoring of risk associated to people's care and the lack of submission of statutory notifications had not been identified before this inspection.
- The service had a registered manager in place but the day to day running of the service was the responsibility of the business manager. We found management's oversight of accidents and incidents and compliance with legal requirements was not always robust.
- Most people and relatives told us care was provided by a regular team of staff.
- People and relatives told us they had been involved in setting up and reviewing their care and were confident that any concerns raised to the provider would be appropriately acted upon.
- Staff told us they enjoyed their job and most of them felt well supported through regular supervision and assessments of their competency and training.
- The provider had developed several links with the community and partnerships to support care provision and service development.
- For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Ratings at last inspection:
At our last inspection the service was rated good overall. Our last report was published on 16 September 2016.

Why we inspected:
This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Enforcement:
Information relating to the action the provider needs to take can be found at the end of this report.

Follow up:
We will continue to monitor the service to ensure that people received safe, high quality care.

Further inspections will be planned for future dates. We will follow up on any breaches of regulations at our next inspection.

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?

Good

The service was effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was 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.

Beckside Court

Detailed findings

Background to this 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
This inspection was conducted by one inspection manager, one adult social care inspector and an assistant inspector.

Service and service type:
The service was a domiciliary care agency.

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. The registered manager was not based at the service location and they were not overseeing the management of the regulated activity on a day to day basis. This was delegated to the business manager, who had been in post 10 weeks prior our inspection, and the assistant director. Both were available during this inspection.

Notice of inspection:
We gave the service 48 working hours' notice of the inspection visit because we needed to be sure that they would be available to speak with us during the inspection.

Inspection site visit activity started on 18 March 2019 and ended on 27 March 2019. We visited the office location on these two dates to see the assistant director, business manager and office staff; and to review care records and policies and procedures.

What we did:
Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the CQC. A notification is information about important

events which the service is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to decide which areas to focus on during our inspection. We requested and received feedback on the service from the local safeguarding teams and commissioners.

During the inspection, we spoke with three people using the service and seven relatives of people using the service. We spoke with eleven staff; this included the assistant director, business manager, quality assurance manager, information governance manager, human resources advisor, care coordinators and care workers. We looked at care records for nine people using the service including support plans and risk assessments. We analysed three medicine administration records. We reviewed training, recruitment and supervision records for three staff including recent observations of their competencies. We looked at various policies and procedures and reviewed the quality assurance and monitoring systems of the service.

After the inspection, we exchanged emails with the assistant director for additional evidence and updates on the actions being taken by the provider following this inspection.

The report includes evidence and information gathered by the inspector manager, inspector and assistant inspector. Details are in the key questions below.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: Some aspects of the service were not always safe. There was an increased risk that people and staff could be harmed.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe with the care they received and this had a positive impact on their life. One person said, "Yes [I feel safe], they are so good to me, the continuity care, having carers that know me, I feel more confident." Relatives agreed their love ones received safe care, one said, "Yes, very safe." Staff had received training in safeguarding adults, knew how to identify abuse and how to raise a concern.
- We reviewed safeguarding concerns that had been dealt by the provider and we were reassured appropriate actions had been taken, such as managing the immediate risk, asking people if they wanted concerns reported to the local safeguarding team and, when relevant, contact the relevant social workers involved. However, the provider had not submitted the appropriate statutory notifications to the CQC and this constituted a breach of regulation 18 of the (Registration) Regulations 2009. We discussed this issue with the business manager and quality assurance manager and they told us the specific actions they were putting in place to address it. We will follow this up at our next inspection.

Assessing risk, safety monitoring and management

- We looked at how people's risks were assessed and managed and we found the provider did not always have a consistent approach in place. Some people had a range of detailed risk assessments to look at different areas of their care however other known risks to people's care had not been assessed. For example, one person's records indicated there had been incidents of aggression towards staff but there was no information about this risk in this person's risk assessment or how staff were advised to manage it. We discussed this issue with the business manager; they told us care to this person was given by a regular team of care workers who knew how to manage this risk and new staff were given verbal handover before delivering care.
- These findings constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.
- We could not be reassured the system in place to manage incidents of late or missed care visits was always effective. There was an electronic call monitoring service in place to alert staff in the office or out of hours if care staff had not attended the visit and this was monitored by care coordinators. However, not all people being supported by the service were covered by this system. We also found three instances when relatives had contacted the provider in relation to care workers being late and this had not been previously identified by the call monitoring system. We discussed this issue with the business manager; they told us they would take the necessary actions to address it.

Using medicines safely

- People told us they were either able to self-medicate or felt safe with staff's support with their prescribed medicines. Comments included, "Oh yes [care workers support me] every morning and evening" and "The

carers give it [medication] to me."
● At this inspection, we found the provider was were not always safely managing the risks associated with the unsafe management and handling of medicines because information on people's care plans and medication administration sheets (MARS) did not always provide the necessary level of detail to instruct staff and reduce the risk of medication errors. For example, people's care plans or MARS did not indicate where creams should be applied and how often. Some people were being supported with their medication jointly by care workers from Locala homecare, other care agencies or relatives however people's care plans did not clearly indicate when this responsibility was shared. There had been an incident of a person being given the same medication twice by a care worker and a family member.
● These findings constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.
● The provider had identified in their internal audits that this was an area that required improvement and actions were being taken to address the issues such as involving the provider's Medicines Optimisation Team to provide support when a new person started their care and additional competency assessments on staff.

Learning lessons when things go wrong
● At this inspection, we found the provider was open and transparent when accidents had happened and staff were supported to report any concerns. The provider told us they had learnt from when concerns had been identified; for example changes were made to staff's training and induction following a complaint. However, we could not be assured the management team had kept an appropriate oversight of accidents and incidents and had put measures in place in a timely way to prevent incidents happening again. For example, on the 7 February 2019 a medication error occurred when a staff member gave a person medicines that had already been administered by a family member. This person had to be checked by the paramedics. On the 18th February 2019, during an internal audit, the provider identified issues with their medicines management, including the level of detail in the "written process for the administration of medications." However, at the time of this inspection, people's medication care plans still did not include detail of when responsibility for administering medication was shared with relatives or other providers which meant necessary improvements had not yet been implemented to prevent similar accidents happening again.
● The business manager showed us a tool they had developed and were planning to implement from April 2019 to monitor and analyse any trends and patterns in accidents and incidents and other critical occurrences.

Staffing and recruitment
● People were supported by staff who were safe to work with them.
● People and relatives told us they usually knew who were going to provide care.
● People and relatives gave us mixed views regarding care workers missing or being late for their visits. We spoke with the business manager about this and they told us people who were being supported with a hospital discharge or a contingency care package were advised by the hospital discharge teams that specific call times will not be guaranteed but will fall within a specified time period and this was discussed before the service started to deliver care. However, the business manager acknowledged some people could develop an expectation of care call times and they told us they would work with them to make sure this information was made clear to people.

Preventing and controlling infection
● The provider was managing the risks of cross infection appropriately. Care workers had completed training in infection control prevention and told us they had access to personal protective equipment (PPE), including gloves and aprons. The provider was completing hand wash audits. Our conversations with

people and relatives confirmed this. One person told us, "They [care workers] wear aprons and gloves."

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

Good: People's outcomes were consistently good, and people's feedback confirmed this.

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. We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- People told us they were able to make decisions and staff respected them. One person said, "They do ask [permission], they ask if I'm ok whist doing the duties." Our conversations with staff confirmed they knew the importance of asking people consent before providing care and offering choices.
- The provider asked people to sign written consent forms before commencement of care and made a note on people's file when a mental capacity had been completed by the referrer. The business manager told us information about people's ability to make decisions was "captured holistically" during their assessment of needs and support planning however, the provider had not completed decision specific mental capacity assessments and best interest decisions for people who lacked capacity. The business manager had already identified this area as requiring improvements and told us about the actions they planned to take to address this issue. For example, we saw a leaflet they had developed and given staff that included information about the principles of the MCA. Staff we spoke with confirmed receiving and reading this leaflet.
- Staff had received training in the MCA and understood how to apply it in the delivery of care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's physical, mental health and social needs were assessed and their care and support was planned through the development of a care plan. However, the level of detail in their assessments was dependent on the type of care the person was receiving. For example, we found less detail in the assessments of people who were receiving care while waiting for another provider. We spoke with the business manager about this and they told us they were planning to implement a short term needs assessment.
- People's needs in relation to the protected characteristics under the Equalities Act 2010, were taken into account in the planning of their care. People's communication requirements were assessed and included in their care plans. For example, one person's communication care plan indicated, "I am able to communicate a little but I am slow to answer and my voice is very quiet." This person's care plan gave clear guidance for care workers "to communicate effectively ensuring [person] fully understands, speaking slowly."

Staff support: induction, training, skills and experience

- People and relative told us they felt staff were well trained and had the right skills to provide support they

require. One person told us "Oh yes, the two I have are top class." One relative commented, "Yes, the fact that they have same carers it gives me peace of mind they know what [relative] needs; one of the reasons we stayed with Locala is this continuity."

● New members of staff had been through an induction period which included online and classroom training, checks on their knowledge and shadowing shifts with more experienced members of staff.

● Staff had access to varied and relevant training. The training plan which was up to date.

● People were supported by staff who had been supported by regular supervision, appraisal and observations. Most staff told us their supervision meetings were supportive. When we reviewed these records, we found records of supervision meetings were succinct and did not always show a two-way conversation had taken place. We discussed this issue with the business manager and they told us they were planning to implement a new supervision template and give further guidance to care coordinators to improve this area.

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

● People were supported to eat a balanced diet that met their needs and in accordance with their preferences. One person commented, "My meals are bought from [grocery retailer] and they [care workers] help by asking what I want out, they keep everything clean and tidy."

● People's care plans included information about their nutritional needs and records of care delivered confirmed support being provided.

Staff working with other agencies to provide consistent, effective, timely care

Supporting people to live healthier lives, access healthcare services and support

● People and relatives told us staff had contacted other healthcare professionals when required. One person said, "I collapsed in the bathroom and they [care workers] got an ambulance, within 8 minutes I went into hospital and they were so kind and gentle when I came back."

● The records we looked at confirmed referrals had been made when necessary and the provider maintained regular contact with relevant services such as the occupational therapists, district nurses, palliative nurses.

Good

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

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- During this inspection, we received consistently positive feedback about the approach of staff on the care and support delivered to people. We asked people and relatives if staff were kind; people's comments included, "Yes, very." Relatives said, "Oh extremely so, [relative] is happy with the support, I trust them;" "Yes they are lovely, it means so much, I have no qualms with them being there, it's nice to feel so secure that they care."
- Staff talked about people with kindness and consideration for their needs and preferences.
- The office and care staff had a good understanding of protecting and respecting people's human rights. People received care and support which reflected their diverse needs in relation to the protected characteristics of the Equalities Act 2010. One relative told us, "One male carer, right in the early days, came but I complained and they never went back again." The assistant director told us people have the option to request a certain care worker on the basis of sex, race, religion, sexual orientation and cultural requirements and language; this was recorded in the system where rotas were generated.

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

- People and relatives told us they were involved in decisions about the care delivered by the provider. We also asked if people and relatives knew where the information about their care was. One person said, "Yes, in the folder, they asked me what I needed, social worker came to do that." One relative said, "Yes, they spoke to me, social services assessed [relative] but they spoke to me."
- Records that we looked at confirmed regular reviews were taking place and involving the relevant people.

Respecting and promoting people's privacy, dignity and independence

- People's dignity and privacy was respected. People told us staff respected their choices. Relatives confirmed this, "Yes they are very good, [relative] enjoys a laugh and a joke with them;" "[Relative] isn't very independent, they make sure everything is where it needs to be so [relative] can reach it."
- Staff we spoke with demonstrated how they provided care that was respectful. For example, one staff member said that when providing personal care they, "start with the top, make sure [people] are comfortable, ask them what they want me to do and keep them covered up."
- The service ensured they maintained their responsibilities in line with the General Data Protection Regulation (GDPR). GDPR is a legal framework that sets guidelines for the collection and processing of personal information of individuals. Records were stored safely maintaining the confidentiality of the information recorded.

Requires Improvement

Is the service responsive?

Our findings

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

Requires Improvement: People's needs were not always consistently met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● People and relatives told us they received a flexible and personalised service that was responsive to their individual needs and preferences. People's told us staff responded appropriately and quickly; one person said, "Yes, they get me anything if I need it." One relative told us about the support provided by the service when their loved one required a new piece of equipment. Another relative said, "[Relative] wasn't well and the times needed to be changed so I raised it and after a week they had changed it; the office [staff] is very good and accommodate the needs where they can."

● We found inconsistency in the quality and level of detail of people's care plans. Some reflected people's choices, wishes and preferences and things that were important to them. For example, one person's care plan detailed the care tasks staff should provide at each care visit; this person's care plan also had information about their hobbies such as "[Person] likes classical music and reading". However, other people, in particular those receiving support after a hospital discharge or waiting for another provider, had very succinct information in their care plans. One staff member told us that information on the care plans of people "receiving temporarily service is quite basic." Another staff member described how a person using the service was "meticulous in how [person] liked to have a shower"; we asked if this information was in their care plans and staff said, "It is not written in the care plan, it does not go to that level of detail." This staff member told us there was a good communication between care staff supporting this person and they were reassured all knew how this person liked to be supported. We discussed with the business manager the importance of people's care plans being detailed and they told us they would review the quality of the information in people's care plans.

● People's care plans indicated some of their personal goals. For example, one person's goal was "To stay positive and enjoy my life." However, there was limited or no information the action staff needed to take to support people in achieving those goals and we found several examples of these goals not being regularly reviewed. Discussing people's personal goals ensures that people receive the care to achieve what they want however it is important people's goals are reviewed to make sure these remain meaningful and staff have clear guidance about how this provide support.

● These findings constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

● Care staff completed relevant daily notes which evidenced the care provided. The provider had carried out an internal audit on daily records and identified improvements were needed in how staff were recording the choices offered to people.

● The Accessible Information Standard (AIS) is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The assistant director told us they could adapt how they made information available to people if they required it and told us how they had done this in the past.

Improving care quality in response to complaints or concerns

● People and relatives told us if they had any concerns they would not hesitate to discuss them with care staff or management and were confident their concerns would be acted on.

● We reviewed complaints received by the service and these had been managed appropriately.

End of life care and support

● The provider was caring for people who required end of life care. Staff had received additional training and told us how they would appropriately support people at the end of their lives, and their relatives. We saw the provider had established close working relationships with relevant healthcare professionals providing this specialised care. We saw compliments from relatives of people who had been cared for at the end of their life. One relative said, "I just want to say thank you for allowing [relative] to be kept on the Continuing Care package for the final three weeks of [their] life. We were so relieved and grateful that [relative] didn't have to get used to new carers when [relative] was so poorly. Please would you pass on a huge 'thank you' to the carers who looked after and supported [relative] and [relative] with such care and patience in the final weeks, especially [names of care workers]."

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

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service had a registered manager however the day to day management of the service was done by the business manager with support from the assistant director. Information about the management of the service was made available to the registered manager through regular (monthly and quarterly) reports and meetings where high level performance of the service was discussed. At this inspection, we found management's oversight had not always been robust in identifying where improvements were required in how risks were managed and how information was used to prevent accidents and incidents happening.
- During this inspection, we found a lack of consistency in the quality of records relating to risks to people's care, support they required and consent.
- We discussed these issues with the business manager and they told us how they were planning to improve the systems in place to ensure an appropriate management oversight of the service delivered. However, because this had not been implemented yet we could not confirm its effectiveness at this inspection.
- These findings constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.
- The provider had not submitted statutory notifications in relation to safeguarding concerns. This is important to ensure CQC can monitor the safety of the service people receive. This evidence constitutes a breach of regulation 18 of the (Registration) Regulations 2009.
- People and relatives spoke positively about the management of the service and most were aware that there was a new manager in place. Staff told us the new manager was approachable and one staff member said, "We'll do everything we can to help her."

Continuous learning and improving care

- A variety of regular audits and quality monitoring were taking place. Whilst findings were recorded and there were plans in place to improve the quality of the service with clear timescales and who was responsible for completing them, these had not always been effective in identifying the shortfalls identified at this inspection, such as the quality of care plans or how consent was recorded for people who lacked capacity. After our inspection, the provider sent us an updated improvement plan.
- The business manager told us they attended local networks of providers who shared good practice and learning. The quality assurance manager told us how they kept informed about relevant good practice and

guidelines and how they escalated this information to the manager.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There were systems in place to ensure communication to staff including phone calls, text messages, staff meetings and a newsletter. Records we looked at showed staff meetings were being held regularly. Our conversations with staff confirmed these meetings were a safe space to discuss relevant aspects of their work.

● Surveys were given to people who used the service and their family members. The provider was waiting for the results of the recent survey.

● The provider's improvement plan included specific actions to improve the communication with people, relatives and staff.

● We saw several examples of compliments and positive comments from people and relatives. These included, "I am writing on behalf of my family to say a big thank you to [name of care workers] for their care of my [relative] in [their] last days. [Care workers] have been very professional in their duties, but very much more than that. They have been positive and full of warmth at a very distressing time. As a family we would like to say thank you."

Working in partnership with others

● The provider had established good working relationships with other organisations and was involved in activities to promote continuous learning and promote people's involvement in meaningful activities if they wished so, such as a befriending service.

● Evidence we looked at demonstrated the service was in close contact with a wider professional team in the community to address specific needs of people, for example, manual handling assessors and social workers.

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 17 HSCA RA Regulations 2014 Good governance There was a lack of consistency in the quality of records relating risks to people's care, support required and their consent; and management's oversight has not always been robust.