Always Here for You Ltd

Holmfield mills Holmfield Halifax HX36SN offces 3.12 and 3.13

Inspection report

Holmfield mills Holmfield Halifax HX36SN offces 3.12 and 3.13
Holdsworth Road
Halifax
HX3 6SN

Tel: 01422303663
Website: myhomecare.co.uk

Date of inspection visit:
15 April 2021
19 April 2021
21 April 2021
23 April 2021

Date of publication:
08 June 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Holmfield mills Holmfield Halifax HX36SN offces 3.12 and 3.13 (known as My Homecare Halifax) is a domiciliary care agency providing support to people in their own homes in the community. 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. At the time of the inspection the service was providing personal care to 22 people.

People's experience of using this service and what we found
People were not always safe. Safe recruitment processes were not followed as required checks had not been completed before staff started work. Risks to people's health and safety were not fully assessed or mitigated. Medicines were not managed safely. Safeguarding incidents were not always recognised or reported to the appropriate agencies. Staff in the office were not wearing PPE in accordance with government guidance, although this was addressed immediately when we raised it with the registered manager.

Overall people and relatives were satisfied with the service provided and said most of the staff were good. Although they observed the service was short staffed which impacted on the timing of calls. Staff said call rotas were disorganised and travel time between calls was not always sufficient.

Systems to assess, monitor and improve the service were not effective.

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 was requires improvement (published 4 December 2019) and there were two breaches of regulation. The provider did not complete an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe 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 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.

We have identified breaches in relation to recruitment, safe care and treatment and good governance at this inspection.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Holmfield mills Holmfield Halifax HX36SN offces 3.12 and 3.13

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.

Inspection team
One inspector carried out the inspection.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service has a manager who is also the provider and is registered with the Care Quality Commission. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity began on 15 April 2021 when we visited the agency office and was completed on 23 April 2021.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority commissioning and safeguarding teams. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and two relatives about their experience of the care provided. We spoke with seven members of staff including the registered manager, the administrator and care workers. Discussions with people who used the service, relatives and staff were conducted either on site or via telephone calls. We reviewed a range of records. This included three people's care records and a sample of medication records. We looked at three staff recruitment files. A variety of records relating to the management of the service, including some policies and procedures, were reviewed.

Inadequate

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 requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure staff were recruited safely. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider was still in breach of regulation 19.

Staffing and recruitment

- Recruitment processes were not safe as the provider was not following their own recruitment policy and carrying out checks to ensure staff were suitable to work in the service.
- Disclosure and barring service (DBS) checks were in place. However, one staff member's DBS check was received four months after they started in post. Another staff member's DBS check was dated ten months after they started. The registered manager said this staff member had a previous DBS check, however there was no evidence to show when this was completed.
- Written references were in place. However, for one staff member it was not clear which organisation had provided the reference or in what capacity they knew the person. For another staff member there was no reference from the last employer.
- There were no interview records for two staff members.

The lack of robust recruitment processes meant people were placed at risk of harm. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives noted the service had been short staffed recently. They said staff usually arrived on time but did not always stay the full length of the call. One relative said, "They can be a bit early on bed calls, particularly at weekends." Another relative said, "The call is for 30 minutes. They're not always there for the full time."
- Staff said call rotas were disorganised, frequently changed at the last minute and there was not always enough time given to travel between calls.
- The registered manager acknowledged there had been a turnover of staff in recent months due to a reduction in care hours. This had meant changes to staff rotas and office staff covering some care calls. They said two new staff had been recruited which would address the shortfall and the rotas were being reviewed.
- Electronic call monitoring was in place, making sure visits had been completed and alerting office staff to any non-attendance.
- An on-call system was in place and staff confirmed this was effective.

Using medicines safely

● Medicines management was not always safe as records were not always accurate.

● Medicine administration records (MARs) did not always reflect the medicines people were receiving. For example, one person's care records showed staff were applying a prescribed cream, however this was not on the current MAR. The registered manager said the cream had been discontinued but did not know when and this was not recorded. The MAR for March 2021 recorded prescribed creams were self-administered, however the registered manager stated this was incorrect as staff applied them.

● Another person's care records showed staff assisted them with medicines administered through a nebuliser. The registered manager confirmed this was not included in the person's care plan or MAR. The MAR for April 2021 recorded a prescribed cream was self-administered, however the registered manager stated this was incorrect as staff applied it.

● Guidance was in place for 'as required' medicines, however this was not person-centred and did not specify in what circumstances the medicine should be given. One person's care records showed 'as required' medicines had been given by staff on many occasions but this was not always recorded on the MAR.

We found no evidence people had been harmed however, systems were either not in place or robust enough to demonstrate medicine were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Risks to people's health and safety were not fully assessed.

● Some risk assessments were in place however others were missing or not fully completed. For example, one person's nutritional assessment scored the risk as high but sections of the form were blank and there was nothing to show the action taken in response.

● People's COVID-19 risk assessments were generic advising staff to wear PPE in accordance with government guidelines. There was no individual guidance to inform staff when to change their PPE during a call.

● Risks associated with people's health were not always assessed and care plans did not provide detailed information. For example, one person's records showed they were diagnosed with dementia, diabetes and hypertension. There was no information in their care plans to tell staff what care and support was required in relation to these conditions.

● The registered manager acknowledged improvements were needed and told us this was being addressed.

Preventing and controlling infection

● Staff were accessing COVID-19 testing in accordance with government guidance.

● Staff confirmed they were supplied with appropriate PPE and had completed PPE training. However, we observed staff in the office, including the registered manager, were socially distanced but not wearing masks. This was contrary to government guidance and the provider's own policy. The registered manager took immediate action to address this when we raised it with them.

● The provider's infection control policy did not reflect current government guidance regarding the changing of face masks. However, the registered manager and staff confirmed they did change masks between clients. The employee fact sheet for coronavirus was not up to date and did not reflect current guidance. For example, it stated there was no vaccine available.

We found no evidence people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Safeguarding incidents were not always recognised or reported in accordance with the provider's policy. The registered manager told us of a recent incident of suspected neglect, which they had taken action to address but had not made a safeguarding referral to the local authority. The referral was made when we raised this issue.

● People said they felt safe with staff. One person said, 'Yes I feel safe. The staff are nice. I have a good banter with the ones who come regularly."

● Staff had received safeguarding training and policies and procedures were there to guide them. They understood how to raise concerns.

Learning lessons when things go wrong

● The registered manager told us there were systems in place to report accidents and incidents. However, it was difficult to establish how many accidents and incidents had occurred as some entries were incorrectly recorded. For example, discussions with health care professionals were recorded as accidents.

Inadequate

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

At our last inspection the provider had failed to ensure effective governance systems were in place. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

- Significant shortfalls were identified at this inspection. There was a continued breach in relation to recruitment; issues identified were similar to those raised at the last inspection. We also had concerns around medicines, risk management and infection control. None of these issues had been identified or addressed through the provider's own governance systems.
- There was a lack of effective management and leadership. Staff said the registered manager was kind and approachable however communication and organisation of the service needed to improve. The registered manager said they were appointing a new manager so they could concentrate on their role as nominated individual and confirmed they were not taking on any new packages.
- Information received from the local authority showed the provider had not understood or complied with their duty of candour responsibilities when investigating complaints received from relatives.
- Documentation we requested as part of the inspection was not always provided. For example, complaints log, staff competency assessments and supervisions.
- Effective quality assurance processes were not in place. The registered manager provided no evidence of any quality audits undertaken since the last inspection. The software system used by the provider for care planning and call management provided statistical information around compliance. However, the registered manager confirmed they did not fully understand the performance data system and had booked further training for themselves.
- External quality audits had been completed by the franchise's quality and compliance director in March and April 2021. The audits identified some of the shortfalls we found at this inspection. The registered manager told us they were working through the recommendations however there was no action plan in place to show how and when the improvements would be made.
- The rating from the previous inspection in 2019 was not displayed on the provider's website.

Governance systems were ineffective. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People and relatives told us they were involved in care planning and were generally satisfied with the care and support they received. Comments included; "Some care staff are very good with [family member], others not so good, not as experienced"; "[Registered manager] came out and discussed my care and how I wanted things done. I'm happy with the care provided" and "Staff are respectful but not always skilled at interacting. Most chat with [family member], but some don't and are in and out in five minutes."
- Satisfaction surveys had been sent out to people and received back at the end of March 2021. Overall the results were positive, however there were areas where people expressed dissatisfaction. The registered manager said they had discussed the results with people, however they acknowledged there were no records of these conversations.
- Records showed staff liaised with a range of healthcare professionals to make sure people received the support they needed.

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 Care and treatment was not provided in a safe way to service users as risks were not assessed and mitigated, risks of infection were not controlled and medicines were not managed safely. Regulation 12 (1)(2)(a)(b)(g)(h)

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 17 HSCA RA Regulations 2014 Good governance There were not robust systems in place to assess, monitor and improve the quality of the service, assess, monitor and mitigate the risks to service users and accurate, complete and contemporaneous records of service users care and treatment were not maintained. Regulation 17 (1)(2)(a)(b)(c)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Robust recruitment processes were not in place to make sure staff were suitable and fit to work in the service. Regulation 19 (1)(2)(3)

The enforcement action we took:

Warning notice