Habitat Care Limited

Home Instead Senior Care

Inspection report

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01 August 2018
02 August 2018
08 August 2018

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We undertook an inspection of Home Instead Senior Care on the 1, 2 and 8 August 2018. An Expert by experience made phone calls to people and relatives on the 31 July 2018.

The inspection was announced, which meant that the provider and registered manager knew we would be visiting. This was to ensure the registered manager or someone who could act on their behalf, would be available to support the inspection.

The service registered to provide a regulated activity with the Care Quality Commission in October 2017. This was the service's first inspection since registering and had not been previously rated.

Home Instead Senior Care is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to older people. Not everyone using Home Instead Senior Care receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; for example help with tasks related to personal hygiene and eating. At the time of our inspection there were 60 people receiving personal care and support from the service.

A registered manager was in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was not consistently safe as medicines records were not always sufficiently detailed and cream charts were not in place. Audits were not fully effective in monitoring and improving the quality of the service provided. For example, shortfalls relating to medicines records had not been identified within the provider's audits.

People and their relatives felt improvements could be made to the timing of their visits as some people had to wait over an hour some days for their visit. During the inspection one person's loved one told us how they had experienced the caregiver being late and had to provide personal care and support due to the caregiver not turning up on time. We raised this concern with the Local authority safeguarding team due to the nature of the concern.

People were supported by caregivers who had checks in place to ensure they were suitable to work with vulnerable adults.

People were supported by caregivers who had received training to ensure they were competent in their role. People were not always supported by caregivers who had a good understanding of equality and diversity.

People felt safe and were supported by caregivers who were able to identify abuse and knew who to go to

should they have concerns. People's care plans had environmental risk assessments in place however not all people who required support with their mobility had a risk assessment that confirmed what equipment they required and how caregivers were to support them with this.

Caregivers had an ID badge, and there was an out of hours number for people and caregivers to ring should they require support or assistance after the office had closed.

People's care plans had important information relating to their likes and dislikes, if they had capacity and their personal situation. Where people lacked capacity, there was a mental capacity assessment and best interest decision in place for most people, however one person required this to be undertaken.

People were supported by caregivers who had received an induction and regular supervision. People were supported by caregivers with their nutrition and hydration.

People felt supported by caregivers who were kind and caring and who demonstrated a positive relationship with the people they visited.

People were happy with their care and felt they had choice and control in the support they received.

People felt able to complain, although they felt improvements could be made to the communication and messages left with the office staff.

Caregivers were happy working at the agency and all felt supported.

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

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.

People were not always having their medicines recorded accurately and as required to ensure they had been received safely.

People did not always have their visits on time.

People's care plans did not always have important information relating to their mobility needs.

People were supported by staff who had checks prior to starting their employment.

Is the service effective?

Good

The service was Effective.

People were supported by staff who had received training to ensure they were competent in their role.

People were supported by staff who received supervision and an appraisal.

Most people's care plans had a mental capacity assessment in place.

Is the service caring?

Good

The service was Caring.

People were supported by staff who were kind and caring.

People felt supported by staff who provided privacy and dignity.

Staff prompted people's independence.

Not all staff demonstrated a good understanding of equality and diversity.

Is the service responsive?

Good

The service was Responsive.

People felt part of their care plan reviews which were undertaken every six months.

People were able to complain and were happy to raise concerns should they have any.

Is the service well-led?

Requires Improvement

The service was not always Well-led.

The providers quality assurance system was not always identifying shortfalls relating to the use of body maps for recording where creams should be applied.

The provider sought feedback from people, relatives, caregivers and key players.

Staff felt supported by the registered manager and that it was a nice place to work.

Care Quality Commission

Home Instead Senior Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out by one adult social care inspector and an expert by experience made telephone calls to people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We gave the service 5 days' notice of the inspection visit. This was to ensure the registered manager would be available.

Inspection site visit activity started on 31 August and ended on the 8 August 2018. We visited the office location on the 2 and 8 of August 2018. The registered manager was available on both of these dates.

We spoke with the provider, the registered manager, two office staff and three care staff. We visited two people in their own homes and made calls to 11 relatives and three people to gain their views on the service.

We looked at six people's care and support records and three staff files. We also looked at records relating to the management of the service such as incident and accident records, recruitment and training records, policies, audits and complaints.

We reviewed information we had about the service including statutory notifications. Notifications are information about specific events that the service is legally required to send us. Prior to this inspection we did not ask for a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe due to missing records relating to medicine administration. For example, we found one person's Medicines Administration Records (MARs) were not always recording if their evening prescribed medicines had been administered. We also found two other medicines, one which was prescribed 'as and when', and the other was to treat an infection had not being recorded on the person's MARs record. This meant by having incomplete records it was unclear if the person had received their medicine as required.

We found people had no completed Medicines Administration Records (MARs) where caregivers were applying people with creams and lotions. People's care plans also contained no confirmation for example on a body map of where the persons, cream should be applied and how often.

We also found one person was refusing their medicines. Their Medicines Administration Records (MARs) did not always record if the person had received their medicines and if not why not. For example, one week we found four missing signatures. The record where caregivers recorded refused medicines had no record of the medicines being refused on three of the four dates within a seven-day period.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People felt safe and caregivers were knowledgeable about the different types or abuse and who to go to. When we asked people if they felt safe they replied, "Oh yes. I look forward to seeing them, we get on so well". One relative told us, "I feel very comfortable with them". One caregiver told us, "Safeguarding is about abuse. Physical, mental, financial. I would report to the office, or the police or the local authority."

People were not always happy with their scheduling of their care visit when their regular carer was off or there were unforeseen circumstances. People told us, "Not normally, just at the moment - but that's due to holidays and sickness". Another person told us, "I'm a bit concerned about what will happen during the holidays when they're short staffed". One relative told us, "They're sometimes late, but that's due to traffic". Another relative told us, "I think they schedule [Name] as if [They're] a car driver and make unreasonable demands on [Them]. It's as if they expect [Name] to fly from one visit to the other". One relative told us the visit to the person hadn't happened when required and they had been required to provide the care due to the person needing support urgently. The member of staff arrived an hour and quarter later than they should have.

We reviewed a report of the times people's visits were planned and when they received their visit. We found that, at times, people were receiving their care before their allocated times and on other occasions after the time they should have. For example, one person on four separate morning visits had received their call one hour and 15 minutes after the planned visit time. Another person had received their morning visit one and a half hours earlier on two consecutive days and on other days around this period of time they had received their visit 30 minutes later. The service aimed to provide people with their visits within 15 minutes of the

planned time. This meant people's visits were not always being received when they should or within the 15 minutes allowance. People's visits were scheduled in advanced and where possible with regular staff. The registered manager and member of staff responsible for scheduling people's calls confirmed most visits were allocated to the same caregiver for continuity however all caregivers had a mixture of zero contracts and above which meant at certain times such as Summer holidays and Christmas it could be hard to provide cover.

People were sent a rota which confirmed the time of their visit and the member of staff allocated. People and staff were supported by an out of hours service where people and staff could ring if they required any support or guidance. Office hours were between 9am and 5pm. The on call out of hours service was covered on a rota with the staff in the office. The phone number was the same as that in the day which meant people were only ever ringing one number to get help and support.

People had individual and environmental risk assessments completed within their care plan. These identified any risks and what measures were in place to support the person. For example, if the person required support and assistance with their mobility and what equipment they required. However we found no individual support plan for two people who required equipment for their mobility. This is important as having a clear support plan in place ensures staff know what equipment to use and how to use it. The registered manager confirmed all staff received training in the person's home prior to supporting them. However one relative we spoke with confirmed that one member of staff would often not use the equipment provided and would manually support the person instead. We raised this with the registered manager for them to investigate this concern.

Caregivers were responsible for recording incidents and accidents and raising these with the office. All incidents and accidents were logged onto the computer system. The registered manager confirmed all incidents were allocated onto the computer system. They logged the outcome of the event so that there was a clear audit trail of action taken. However we found during the inspection there was no overview of incident and accidents this is important as by having an overview of incidents and accidents means any trends can be identified to prevent similar incidents from occurring. The registered manager took action to address this during the inspection.

People were support by caregivers who wore personal protective equipment (PPE) such as gloves and aprons when providing personal care and cooking. Caregivers confirmed they wore PPE and that they washed their hands in-between supporting people.

People were supported by caregivers who had checks completed on their suitability to work with vulnerable people. The service had a dedicated caregiver who was responsible for engaging with the local community prompting a career in care. The provider and registered manager felt it was important to get the right staff for the job and that the recruitment process ensured this. Caregivers had a Disclosure and Barring Service check (DBS) in place prior to starting their employment. A DBS check helps providers make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable people. New caregivers had a mixture of personal and professional references in place and their identification was also checked. Potential caregivers had to submit an application form that confirmed their previous employment history. Records confirmed this.

Caregivers had a work bag that contained paperwork, an alarm and personal protective equipment. Staff wore an identification badge so that they could show who they were and where they worked.

Good

Is the service effective?

Our findings

People were supported by staff who had received training to ensure they had the skills and competence in their role. For example, staff received training in moving and handling, medication, safeguarding, mental capacity and infection control.

Most staff were happy with the training they had received, although one member of staff confirmed they hadn't received any moving and handling training since they had started in August 2017. Records confirmed they required training in, moving and handling, nutrition and hydration, food hygiene, medication and infection control. Following the inspection the registered manager confirmed they were booked to attend this training but had not at the time of the inspection undertaken the training. This meant not all staff had received training to ensure they were competent in their role.

People felt supported by staff who were competent. One person told us, "Oh yes, I have confidence in what they do".

Staff received an induction before they started work. This covered training such as medicines, food hygiene and health and safety. Staff shadowed experienced staff to enable them to become familiar with the role.

People were supported by staff who had supervisions and a yearly appraisal. Staff received a combination of one to one supervisions and 'on the spot' supervisions. These were provided every three months. Supervisions were an opportunity to observe staff practice, conduct, training needs and anything else. Staff felt happy and well supported.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Care plans confirmed if people had capacity. Most people had a mental capacity assessment in place where they had been identified as lacking capacity. One person had no mental capacity assessment in place although they lacked capacity. We raised this with the registered manager who acted immediately.

People's care plans confirmed if people had a Power of Attorney and who was the person's representative should decisions need to be made relating to their health and welfare. However not all care plans had copies of these legal documents to confirm the formal arrangements in place.

People were supported by caregivers with their nutrition and hydration if required. Care plans contained important information relating to the persons individual needs and what support the person required from staff. For example care plans confirmed if the person required specialist such as percutaneous endoscopic gastrostomy (PEG). This is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach so that they can have their oral and nutritional needs met safely. Another care plan

confirmed the person was diabetic. Both care plans had clear instructions in what support the person required from their caregivers.

Most people told us they were supported by their relatives if they required support with medical appointments. However records confirmed when caregivers had found people who required medical assistance the caregiver had sought consent and had called the person's GP or an ambulance.

Good

Is the service caring?

Our findings

People were supported by caregivers who were not always familiar with a good understanding of equality and diversity. For example, one caregiver said, "We treat everyone the same and equal". We asked the caregiver when someone might be treated differently due to their individual needs. They confirmed, "Religion. People have different ways of going about things". They were unable to explain or provide any other examples of when someone's diversity would mean their care needed to be provided differently. Caregivers received training in Equality and Diversity during their induction. However caregivers were unable to demonstrate a good understanding following this training.

People and relatives felt caregivers were kind and caring and that they got on well with people. People told us, caregivers were, "Very respectful, very polite, generally very nice people". Relatives told us, "Yes, [caregiver] is very caring – but I only have the one carer". Another relative told us, "She's very polite, we have friendly banter."

People and relatives had formed positive relationships with caregivers and all were happy with the support provided. One person told us, "It's like two good friends coming into look after me". Another person said, "Oh, they know me well – very well". One relative said, "Very good, very satisfactory."

People and relatives felt caregivers respected their privacy and dignity. One relative gave an example of how caregivers support the person with their personal care. The relative told us caregivers make sure they shut doors and pull curtains so that the person they are supporting has privacy as they live in the same house as their relative. One person confirmed that caregivers provide privacy by pulling the shower curtain and getting towels ready but staying outside the shower room whilst they shower. Caregivers were able to give good examples of how they provided dignity and respect to people. One caregiver told us, "I make sure curtains are shut and doors. I also give people choice".

People were supported by caregivers who promoted their independence. caregivers were able to demonstrate how they encouraged people to undertake tasks of daily living themselves. One caregiver told us, "I always ask people before I do anything". Another caregiver told us, "We encourage people to do things. Everyone we approach is different". The caregiver went on to say, we ask, "How do you want it done" and "Would you like to do it". We give, "Choices and encouragement to do things". This meant people were supported and encouraged to regain independence where possible.

People felt in control of their care and caregivers demonstrated how they gave people choice. One person told us, "I choose the care that I receive. I am able to make my own decisions and choose what I want and when". Caregivers gave examples of how they offered people choices. One caregiver said, "I give [Name] a choice about what they want to wear and how they have their care. It is their choice."

Good

Is the service responsive?

Our findings

People's care plans had important information relating to their likes and dislikes, their family, routines and individual needs. For example, one care plan confirmed the person liked to play the piano. It also confirmed the job they had done and details about their family and spouse. Another care plan confirmed what career the person had done including their hobbies and interests. Caregivers knew people and family well. We observed one caregiver talk to the person about a project their spouse was undertaking. The caregiver spoke with interest and enthusiasm to the person which demonstrated a positive relationship had evolved.

People and relatives were involved in care plan reviews. Care plans were reviewed every six months. The reviews were undertaken by the office co-ordinators and registered manager. Records confirmed that care plan reviews were an opportunity for people to discuss any changes to their care needs and anything that Home Instead Senior Care could do better. People felt able to share their experiences and the improvements they felt were required, and records confirmed this. One relative told us, "Yes, [Name] has a care plan - they review it regularly". Another relative told us, "I was involved in writing the care plan."

People and relatives felt able to complain and a copy of the complaints policy was accessible in people's care plans. One person, when asked if they had any reason to complain told us, "None whatsoever". Another person told us, "I've never complained". One relative confirmed when they had raised a concern it had been dealt with quickly. The relative told us, "I've complained once about the office and once about a carer. They sorted it out quickly". They went on to confirm they had received the complaint outcome in writing. Another person told us, "Not a complaint as such. But I always check the timings they record to make sure that they stay as long as they should". The registered manager reviewed all complaints on the 'People planner system'. This confirmed the complaint and actions taken. However there was no overview of complaints made so that they could be analysed for any trends and themes. The registered manager confirmed they were due to put a file together to show complaints received. This was confirmed by the Home Instead action plan however at the time of the inspection this was not in place.

No-one at the time of the inspection was receiving end of life care. Care plans had limited information relating to the person's wishes and how they wanted their care provided. This is important as by having clear wishes in how someone wants their care provided means their views and wishes can be supported should an emergency occur.

Requires Improvement

Is the service well-led?

Our findings

The service was not consistently well-led due to systems that were not always effective in monitoring and reviewing the quality of the service. For example, the registered manager confirmed there was a system in place for monitoring and checking the safe administration of medicines. However we found shortfalls had not been identified relating to incomplete Medicines Administration Charts (MARs) or the use of body maps for recording where creams should be applied. The registered manager confirmed they were aware improvements were required with staff who were not signing MARs charts. This was something the registered manager was working to improve. Improvements were also being made to the logging and recording of incidents and accidents so that trends could be reviewed and actions taken to prevent similar situations from occurring again.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered manager confirmed following the inspection actions they had taken where the service had purchased a safe to keep the person's medicines securely within. They had also asked the GP for a medication review.

The registered manager undertook daily office meetings called, 'huddles'. These were an opportunity for the staff working in the office to update the registered manager on recruitment, any problems or complaints, staffing and calls allocated and how many reviews had been undertaken. Following the inspection, the provider confirmed it was also an opportunity to provide ongoing monitoring of the clients and caregivers safety and well-being.

Caregivers felt well supported by the management of the service and all told us they could go to the registered manager or the provider if they needed to. One Caregiver told us, "I have no problem ringing the office or the registered manager if there is a problem." Caregivers felt it was a nice place to work and that it was a nice team to work in.

Some people and relatives felt improvements were required to communication within the service. One relative said they had left a message for the caregiver but the office had never passed it on. Another relative said, "I have to leave two or three messages before someone calls me back." Another relative said, "They've always been fine with me".

The provider sought feedback through customer satisfaction surveys. Each year questionnaires were sent to people and their relatives, caregivers and other 'key players'. The last survey was in 2017 and the provider was awaiting the result of the 2018 survey at the time of the inspection. Results from the 2017 people and relative survey was mostly positive. With 95% of people feeling the caregiver was matched well to their needs and 96% feeling that the caregiver was on time. 82% of people felt the office team always communicated any changes to their schedule in advance. Along with 80% of people feeling the office team always communicate any changes to their scheduled caregiver in advance. This meant by the provider

seeking feedback, improvements could be made to areas where people's experience was less than satisfactory.

The provider undertook regular recruitment campaigns in the local area. This included local job fares, coffee mornings and community meetings. The provider had produced a video so that they were able to show potential new care givers what a day in the life of a caregiver looked like. The service had a designated member of staff responsible for attracting new potential caregivers into the service.

The registered manager understood the legal obligations relating to submitting notifications to the Care Quality Commission. A notification is information about important events which affect people or the service.

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 Records were not always accurate relating to the administration of medicines. The providers audits were not always effective at identifying shortfalls found during the inspection.