Homecare4U Limited

Homecare4u Worcestershire

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Homecare4U Worcestershire is a domiciliary care agency. People had individual packages of care in their own homes. At the time of this inspection Homecare4U supported 53 people with personal care. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found.
People and relatives told us care staff often turned up late or early and that at times they were not informed that calls were going to be late. Care staff told us that there was not enough time between calls to ensure that they could arrive in time.

People did not always receive safe care. Risks assessments were not updated to reflect current risks to people's safety. Where risks were identified by care staff this was not communicated to everyone that needed this information to keep people safe.

There was no system to monitor call times and the manager did not know when care staff arrived and left. Staff did not consistently log into calls at the time calls were being made. This meant the manager could not establish if people received their agreed care.

Care staff had knowledge of safeguarding and whistle blowing; however, care staff did not always feel supported to raise concerns. Safeguarding procedures had not always been effectively followed. There were examples where actions that should have been taken to keep people safe but were not always taken in a timely manner.

Safe recruitment procedures were not always followed. The registered manager had identified one member of care staff as needing additional supervision and checks to provide assurances as to their suitability for the job. This was not completed, and no assurance could be provided to what actions had been implemented to ensure this care staff member's suitability.

There was no effective governance or oversight of the service or how it was performing.

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.

Rating at last inspection: At the previous inspection in December 2019 the service was rated Good in all areas. At this inspection we have rated this service as requires improvement in Safe, Effective and Well Led. This leads to an overall rating of requires improvement.

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

Why we inspected
We received concerns in relation to the management of risks and safeguarding. As a result, we undertook a focused inspection to review the key questions of safe, effective 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 good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective 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 our 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 identified breaches in relation to the management of risks associated with people's care, recruitment procedures, notifications and governance of the service 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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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 well-led?

Requires Improvement

The service was not always well led.
Details are in our well led findings below.

Homecare4u Worcestershire

Detailed findings

Background to this inspection

The 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 was 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.

Inspection team
The inspection team consisted of one inspector. We visited the service on 22 April 2021. We gathered further information about the service via telephone conversations. We spoke with people and their relatives to gain feedback about the service and had telephone conversations with care staff.

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 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 in the process of leaving the company so was not available during the inspection. Homecare4U had recently been acquired by a new management team but was continuing to operate as Homecare4U. A new manager has been appointed who is in the process of registering with CQC.

Notice of our inspection
Our inspection was announced.

We gave short notice of our visit on 21 April 2021 to the newly appointed manager. Notice of our visit was given because the service was inspected during the coronavirus pandemic and we wanted to be sure we

were informed of the service's coronavirus risk assessment for visiting healthcare professionals before we entered the building, and to ensure the provider was available for their inspection. Inspection activity commenced on 22 April 2021 and ended on 7 May 2021.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work in the service. 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.

During the inspection
During our on-site visit to the service, we spoke with the new appointed manager, area manager and three members of care staff. We reviewed a range of records, including safeguarding records, staff records and records relating to the governance of the service.

After the inspection
We spoke with seven people who used the service and two relatives. We spoke with six members of care staff. We also reviewed the care plans and risk assessments for five people that used the service and reviewed additional documentation that we had requested from the provider.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. Some aspects of the service were not always safe and there was limited assurance about how risks to people was managed. There was an increased risk that people could be harmed. Regulations were not met.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Not all relatives we spoke with felt that risks to people were managed effectively. One relative told us their loved one, "should have two carers, but sometimes only one carer turns up and one person is no good on their own". The relative said this meant they were expected to support the staff with their loved one's personal care and "found this a struggle because of [their] own health". This meant the person receiving care was at risk of injury, as the relative told us, "You cannot move [person] on your own and I struggle with my back, so when one carer here it is not ideal." Another relative told us a member of care staff had turned up with their arm in a sling. They were supporting another member of staff but had been unable to assist with lifting and transferring the person. The relative said they were so concerned they contacted 'the office' to raise concerns.
- Support plans did not always contain the information care staff needed to minimise risks to people's health and wellbeing. For example, a member of care staff told us they had raised significant concerns about risks relating to two people that they supported with the manager. The risks if left unmitigated posed a significant risk to people and staff. We spoke with the manager who confirmed they were aware of the risks; however, they had not reflected these risks in the individuals' risk assessments or care plans. The manager also confirmed that no communication with other care staff had happened regarding these risks. We were not assured any actions had been taken to mitigate these risks. We informed the local authority safeguarding team of our concerns and raised these with the new management team who took steps to ensure these risks were addressed.
- Care staff knew how to report and record accidents and incidents. Whilst accidents and incidents were recorded there was no evidence any analysis of patterns or trends occurred. This meant we could not be assured that there was a system for the provider or staff to learn and share findings of the outcomes of any accidents or incidents. For example, we found details of an incident which resulted in the hospitalisation of a person that used the service. This was the result of an omission of care from the staff supporting the person. We could not see that any analysis of what went wrong had taken place. Steps had not been taken to reduce the chances of the incident happening again. The new management team told us they were in the process of migrating their established audit systems into Homecare4U; however, they told us this would not be until later in the year.

Systems were either not in place or robust enough to demonstrate risk was safely identified or 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

● Care staff had received training and understood their roles and responsibilities in keeping people safe.

● There were systems for care staff in identifying and raising any safeguarding concerns, including procedures for whistleblowing. However, we were not assured that staff would always follow these safeguarding processes. Some staff told us they did not feel comfortable raising concerns and were unsure of what would happen if they became whistle-blowers. One member of care staff said the approach of managers to concerns "does not fill you with confidence." Another member of care staff said they would feel comfortable to raise concerns but said "I do not have complete confidence that managers listen." The new management team told us that they would be changing the culture to reflect a workplace that supports the sharing of concerns from staff.

Preventing and controlling infection

● Adequate steps to manage the risks of cross infection were not always taken by the registered manager or the newly appointed manager. Three care staff gave examples where they had attended care calls while unwell. One member of staff told us, "I was told to sort the cover myself or go into work. If I didn't, I was told I would lose my hours." Another member of care staff said, "We have received a message from the office to say we need to give a week's notice of sickness or risk disciplinary action." A person who used the service told us, "Recently a staff member turned up looking very unwell. I was so concerned I insisted that the staff member call the office and go off sick. The staff member said it was because they were short staffed." We shared this information with the local authority and with the new management team and they provided assurances to the local authority and CQC that revised sickness procedures had been immediately implemented and were being closely monitored.

● Care staff had received training in infection control and understood the importance of using personal protective equipment (PPE) to reduce risks of cross contamination. Care staff had been trained in COVID-19 and understood the importance of following agreed protocols to prevent the spread of COVID-19.

● We found that care staff had awareness of the latest government guidance around the use of PPE and we found that staff had been informed by the provider when guidance changed.

● The provider ensured there was sufficient PPE available at the office and at people's homes, so that care staff could always access PPE when they needed to.

Staffing and recruitment

● The provider did not always follow safe recruitment procedures. We found there were not always adequate checks on staff employment history, references or any potential criminal history. Where concerns had been identified by the provider with a staff member's application, no action had been taken to gain assurances over that person's suitability for working with vulnerable people. Once informed, the new management team took immediate steps with this staff member to gain the required assurances.

We found that the provider had failed to ensure safe recruitment of staff. This was a breach of Regulation 19 (Fit and proper persons employed) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People, relatives and care staff told us they felt there were not always sufficient staff to provide safe care and support. Some people told us that where they expected two care staff to provide care that sometimes only one care staff would attend. The care delivered did not always match the person's assessed needs. The manager acknowledged that there were issues at times in covering calls when care staff were absent.

Using medicines safely

● People, care staff and relatives we spoke with did not identify any concerns in relation to the support people received with medicines.

● Medicines records showed when medicines were administered, and also when care staff reminded people to take their own medicines.
● Care staff were trained in medicine administration and told us they felt they had the skills to support people safely with their medicines. However, care staff told us that they did not have any checks on their level of competence or understanding of medicines. The new management team told us that the new systems of supervision and support for care staff includes 'spot checks' and discussions with staff to gauge their understanding and ensure they worked in accordance with the provider's policies and procedures.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to Requires Improvement. Some aspects of the service were not always effective in meeting people's needs.

Staff support: induction, training, skills and experience

- People and relatives felt care staff had the skills they needed to effectively support them. One relative told us, "I am happy that staff know what they are doing."
- Care staff had mixed views on the quality of the training provided by Homecare4U. One member of care staff said, "Training could be better. They have not come to check that I understand, you just watch the training and say that you have attended." Another member of care staff said, "There is a sign that training is going to improve." Whilst there was a training matrix that showed what training care staff had taken and identified when refresher training was required, there was no system to measure staff skill and competence. The new management team told us that they were going to migrate across their training programme to the staff at Homecare4U.
- Care staff did not feel that they were supported or encouraged to expand their skills and training. One member of care staff told us how they had shown an interest in additional training around end of life care, and how the provider told them this would not be possible. However, staff were positive about the future training prospects under the new management team. The new management team had started to plan individual supervision with care staff so that they could identify individual staff needs.

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

- Care calls did not always happen at the time agreed with the person. Rotas were arranged without travel time in-between. This meant that care staff did not have any time between calls to travel from one location to another. Care staff told us that after the first call they were already running late for the next call. Also, some care staff told us that they would often just get a text message to add another call into their rota for the day, and how this left the staff with having to rearrange their day at very short notice.
- Although there was a system to arrange calls and plan rotas, we were not assured this gave any prospect of realistic achievement of meeting the times identified by people for their care. One relative told us care staff could arrive up to an hour late, and a person that used the service also told us that care staff can sometimes be two hours late. The office manager told us that there were plans to put travel time in-between calls, however this had not been done and the expectation for care staff getting to all their calls on time remained unachievable.
- There was a system providing a view of what calls were being made at the time, however this was reliant upon care staff successfully logging in and out of calls with the app on their phones. This did not always happen, some care staff said they 'forgot' while other care staff reported signal problems with their phones. On inspection we found a person with no call logged as taking place on the system. The call should have

happened five hours before, however no communication had happened with the care staff or person to check if this call had taken place. We were later informed by the manager during the inspection that they had contacted the staff member who said they had 'forgotten' to log the call, but the call had taken place at the planned time. We were not assured that the management team had oversight of where staff were or what calls were taking place, or that people were at risk due to a missed call.

● Care staff worked with other healthcare professionals to support people's health and maintain their wellbeing. One member of care staff told us how they had referred a person to a district nurse because of concerns they had, and how they had followed this up with the district nurse to see if a review was needed on a particular aspect of that person's care.

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

● People had a comprehensive assessment of their needs prior to receiving a package of care. This was done in consultation with people and family members. Some people and relatives told us that they had the agreed level of care and support. Care plans and risk assessments were detailed; however, where care staff had identified some risks associated with people's care with senior staff this was not then detailed in the relevant care records for other staff to follow.

● Protected characteristics under the Equality Act 2010 were considered. For example, people were asked about any religious or cultural needs so these could be met. There were policies to ensure they protected people's, and staff's rights, regarding equality and diversity.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of MCA.

● Care staff demonstrated an understanding of the principles of the Mental Capacity Act 2005 (MCA). People told us that they felt staff were respectful of their choices regarding the care and support. Care staff told us that they made sure people were listened to and given choice in their own homes.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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.

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

- The provider and registered manager had failed to submit the required statutory notifications to CQC. Statutory notifications alert CQC to events that may affect the health, safety and welfare of people that use services. For example, the provider had failed to inform us of one incident which had resulted in people coming to harm, although they had notified the local authority. The local authority made us aware of this incident and had taken steps to investigate and safeguard people.

The provider failed to submit statutory notifications to CQC. CQC were not notified of events that resulted in risks to peoples safety and welfare. This was a breach of Regulation 18 (notification of other incidents) Care Quality Commission (Registration) Regulations 2009

- Concerns we raised with the manager around how calls were scheduled on rotas had not been actioned in a timely way. This had meant that expectations of care staff arriving on time to calls remained unrealistic.
- Management decisions which had a negative impact on people that used the service and care staff continued to be made. Concerns remained regarding the management of infection control and staff sickness.
- Risks identified to the management by care staff during the inspection had not been reflected in people's care plans and risk assessments. This left risks unmitigated and continued to present a risk to the health, welfare and safety of people that used the service.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There were no systems in place to identify lessons learnt from incidents or concerns. The lack of management overview and governance of the service meant steps to improve the care provided had not been identified or taken.
- The provider's quality assurance systems had not identified the issues we identified at this inspection. This included the concerns we found in relation to staff recruitment practices, staff competency checks, management of staff sickness and the scheduling and monitoring of care calls. There were inconsistent systems of governance and oversight of what was happening on a day to day basis.
- Quality assurance systems had failed to highlight all the risks to people's health and safety were appropriately identified and assessed. Risk assessments did not always contain the information needed by

care staff to provide safe and effective care and to reduce risks to people. Systems were not robust enough to ensure that the risks and safety of people was effectively managed.
● We were not shown evidence of where audits and quality monitoring had taken place. Although the area manager told us that phone calls and spot check visits were made to people, checking on the quality of care they were receiving, records were not made of the outcomes of these calls or visits. The people and relatives we spoke with during the inspection did not remember having any of these calls.

The provider's governance was not effective, including quality assurance and auditing systems. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although there was a registered manager still in post, they were in the process of leaving Homecare4U and not available during the inspection. The new manager, who was available during the inspection, had applied to CQC to become registered manager of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
● Care staff did not feel the working environment was conducive to learning and professional development.
● Care staff did not feel supported to raise concerns and felt under pressure to work when ill. This did not promote a positive or safe culture.
● The provider's systems had failed to ensure peoples individual preferences were always achievable. They did not allow for people to have their preferred times for calls from care staff. This meant people were not always supported in line with their preferences.

Working in partnership with others
● The provider had not always demonstrated effective partnership working. They did not always engage with CQC or the local authority when concerns had been raised.
● The new management team has already taken steps to improve communication and partnership working. For example, following feedback regarding this inspection the provider has taken immediate steps to address the concerns. They were working with the local authority to reduce their commissioned care packages so that the amount of care provided was more reflective of what the provider could deliver safely.

● We discussed our concerns and feedback with the provider following our inspection. The new owners told us they planned to bring their own care and governance systems into Homecare4U in the 'next few months'.
● The new management team told us they remained committed to changing the culture and management of 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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to submit statutory notifications to CQC. CQC were not notified of events that resulted in risks to peoples safety and welfare.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people's safety and welfare were being assessed and planned for.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure staff had been recruited in line with their recruitment policy.

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 The providers governance arrangements had failed to ensure people were receiving safe and effective care and support. There was no system to identify areas where improvements were needed.

The enforcement action we took:

We have served the provider with a Warning Notice.