Homelife (Leeds) Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Homelife (Leeds) Limited is a specialist domiciliary care agency which supports people who are deaf and hearing impaired or have complex additional needs living in specialist housing. It is part of an organisation, which also has supported living and a day care facility. It provides personal care to people living in specialist housing. It provides a service to older adults, people who misuse drug and alcohol, people with dementia, learning disabilities or autistic spectrum disorder, people detained under the mental health act, those with mental health issues, sensory impairment and younger adults. At the time of the inspection there was only one person receiving a service.

Not everyone using the service receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection there was only one person in receipt of personal care from the service.

This announced inspection took place on 24 July, 1 and 2 August 2018.

There was a registered manager in post at the time of our inspection. The registered manager was also the director and there was a separate manager who had day-to-day responsibility for managing the service. 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.

At the last inspection we rated the service overall 'Good.' However, at this inspection we found that improvements were required and rated the service 'Requires improvement. Improvements were needed to fully ensure effective systems and processes were in place to monitor and improve the service. Audits were not always carried out to identify any shortfalls in the service and records of incidents that occurred within the service, such as people falling and sustaining serious injuries, did not always record when actions had been taken to prevent re occurrences.

We could not be sure that people received the medicines they needed as records linked to the administration of medicines were not always signed by staff to reflect administration process and if people actually took their medicines. We found some medications had been omitted by staff and write that these had not been administered due to the lack of information provided to ensure safe administration.

Not all staff understood the Mental Capacity Act 2005. The person using the service did not have capacity. We found the provider did not include information to reflect that assessments had taken place as they lacked capacity. No systems were in place to monitor if a person's capacity had been reviewed.

Some staff told us they did not always feel supported by the registered manager as they were not present.

Staff meetings took place and staff were encouraged to discuss proposed improvements for the service. However, some staff felt issues they raised had not always been acted upon.

Staff received supervisions and appraisals in line with the provider's policy. Inductions took place and staff received appropriate training although we discussed with the provider that staff would benefit from further training in the MCA Act 2005, to improve their understanding and application of this Act. Improvements had been made to ensure staff's knowledge remained relevant and training was monitored to ensure staff completed their training.

The person who received care told us there was enough staff to meet their needs. Staff were recruited in line with the provider's policy and these checks were robust.

The person receiving care told us they felt safe. Staff knew how protect people from potential harm or abuse. Risk assessments were completed and reviewed to support people with specific needs to avoid any harm.

Where people required assistance, they were supported to eat, drink and maintain a balanced diet. People were also supported with their health needs and annual checks carried out. Staff liaised with health care professionals and supported people to attend appointments.

The person using the service had good relationships with staff and told us their needs were met. People were encouraged to be independent and make choices regarding their care. Staff respected people's privacy and dignity when in their home.

Care plans were carried out and provided instructions for staff to follow. At the time of our inspection the deputy manager was reviewing the person's care plan we looked at in collaboration with the local authority, to make sure this was adequately person- centred. People received personalised care which responded to their specific needs and preferences.

Staff used individualised communication skill assessments to determine levels of dependency and support required from staff. We found a variety of methods were used to communicate with people including British sign language, writing on whiteboards and picture cards to support people to make decisions about their care and to give consent.

The provider had not received any complaints in the last 12 months but knew how to respond and investigate any concerns raised. There was also an application available to staff so they could raise concerns directly with the management should they wish. The person using the service told us they felt confident to discuss any concerns with the provider.

Surveys were provided to people using the service to monitor the quality of the care provided.

We identified one breach of the Health and Social Care Act (Regulated Activities) Regulations 2014; you can see what action we told the provider to take at the end of the full version 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.

We could not be certain that medicines had been administered due to the lack of recording on MARs. There was no monitoring of medicines and errors had not been investigated.

The person using the service told us staff met their needs and there was enough staff.

Accidents and incidents were recorded other than medication errors, however, actions had not always been recorded to show lessons learnt.

The person using the service told us they felt safe and staff had a clear understanding of how to protect people from possible harm or abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked capacity to make decisions, capacity assessments were carried out by the persons case manager. We found the provider needed to confirm staff understood the MCA and ensured all best interest decisions were carried out.

Not all staff felt supported although we did see evidence that supervisions and appraisals had taken place in line with the provider's policy.

There was an induction and training programme in place for staff.

People were supported to meet their health and nutritional needs and to access professionals, when needed.

Is the service caring?

Good

The service was caring.

The person using the service had good relationships with staff

and we observed positive interactions between them.

Staff treated the person with dignity and respect and they were supported to be independent. Staff involved the person and provided explanations to them, so they understood about their care.

British Sign Language was used to communicate but other varieties of communication were used including picture cards and white boards to write on, so the person could be included and make informed choices about their daily life.

Is the service responsive?

Good

The service was responsive.

People had individualised care plans which met their needs. They and the people that mattered to them had been involved in identifying their needs, choices and preferences and how these should be met.

Regular reviews of care plans took place and we found this was been carried out in collaboration with the local authority.

A complaints procedure was in place and the provider told us how they would investigate any concerns raised. People using the service knew who to communicate with if they wished to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audits were not always carried out to monitor the service and to prevent re occurrences of incidents or issues.

There was a lack of records to show when actions had been taken, written documentation was not always clear and some information was difficult to obtain or find.

There were mixed views about the support received from the registered manager and the deputy manager. Staff meetings were held and the provider had developed positive community links to ensure people did not feel isolated.

Homelife (Leeds) Limited

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.

This comprehensive inspection took place on 24 July, 1 and 2 August 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the registered manager would be in. The inspection was carried out by one adult social care inspector and a British Sign Language interpreter. The second and third days were also announced.

Before our inspection, we reviewed all the information we held about the service, including previous inspection reports and statutory notifications sent to us by the provider. Statutory notifications contain information about changes, events or incidents that the provider is legally required to send us. We also contacted the local authority, commissioners, safeguarding and Healthwatch to gather their feedback and views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We reviewed 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 the information that we gathered to inform the planning of this inspection.

At the time of the inspection there was only one person receiving a service from Homelife (Leeds) Limited. We visited the person receiving personal care to speak with them about the care they received. We were informed the person was only able to communicate with us using simple British Sign Language. We also spoke with four staff members, the registered manager, the manager, the deputy manager, two communication leads one of whom was also the training lead. We spent time looking at documents and records relating to people's care and the management of the service. We looked in detail at the person's care plan, medicine records, three staff personal files and a variety of policies and procedures developed and implemented by the provider.

Requires Improvement

Is the service safe?

Our findings

The person using the service told us they received their medicines. However, we found some recording issues and medication errors, which had not been investigated to prevent future occurrences. We looked at the person's medication administration records (MARs) which did not always include details of the medication administration times, the dose or where to apply creams. For example, we found one MAR which had 16 missed signatures for regular prescribed medicines. We found a small number of incidents where staff had not administered topical medicines (creams) as there were no instructions about where to apply this on the MAR. The staff had not followed the provider's own medicine policy because any omitted medicines should have been fully investigated to identify why the medicine was not given to ensure this does not re occur, and such an investigation had not happened.

We found several medicines that had been prescribed but there were no details on the MAR which would indicate if the medicine was a regularly prescribed medicine or 'as required'. There were also no details of the doses to be given and times of when to administer. We found this for six medicines.

We discussed these shortfalls with the deputy manager and asked whether audits were carried out to check for errors or missed medicines. The deputy manager and director confirmed that no medication audits had been carried out and the deputy manager confirmed that no medicine errors had been recorded on incident forms. This did not follow the provider's medicine policy which stated a medication error should be reported and investigated. The provider's policy also stated, 'Audits should be conducted on any reports of medication errors so that lessons can be learnt' however, this had not taken place to ensure people received their medicines as prescribed.

Medicines were stored in the person's bedroom in a cupboard with a secure lock. The deputy manager told us that stock checks had not been completed to ensure the correct amount of medicines were being administered. We found body maps had not been used to show where creams should be administered. We informed the manager of this and on day two of the inspection body maps had been put in place.

We recommend the provider revisits their overall management of medicines to include the records relating to medicines and the recording of the administration of medicines.

The person using the service told us there were enough staff to meet their needs and that staff helped them when needed. The person received one-to-one time with staff and we observed this happening during the inspection. Staff expressed a different view and told us, "To be honest I don't think there is enough staff. This was bought up at the last staff meeting but nothing happened" and "We are short staffed, we have been for months. People have one-to-one funded time, but staff can't do this because of the lack of staff on shift." Although staff felt there was a lack of staff the person receiving care told us their needs were met and therefore this had not impacted on the person's care.

We checked whether staff who had been recruited were of good character to work with vulnerable people. We looked at three staff files and found robust recruitment procedures had been carried out.

The person who used the service told us they felt safe. Staff were aware of the policies and procedures to follow should they suspect any harm or abuse and understood the different types of abuse that may occur. There was a whistleblowing policy which staff could use to report any concerns and staff told us they felt confident to raise any issues.

Risk assessments had been carried out, reviewed and updated when needed. We looked at a risk assessment which informed staff of measures to take to prevent the person from falling. This included the use of a wheelchair to support when the person was out in the community. Staff also supported the person when standing and sitting and ensuring all obstacles were removed from the floors to prevent possible falls. Monitoring sheets were used to record any falls to determine trends and themes. We saw another risk assessment regarding urinary catheter care and instructions for staff to change and empty this regularly to prevent possible infection and risk to the person.

Apart from medication incidents we found all other accidents and incidents were reported and recorded. For example, there were medicine errors as staff had failed to follow the provider's medicines policy. The policy stated if medicines were omitted and not given an investigation should be commenced however, this had not taken place. We found actions had not always been recorded with lessons learnt to prevent future incidents. The deputy manager told us they discussed actions to take with the registered manager, but this had not always been recorded. We have addressed recording issues within the well-led domain.

Requires Improvement

Is the service effective?

Our findings

Not all of the people who used the service had the mental capacity to make informed choices and decisions about all aspects of their lives. 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We discussed whether anyone in receipt of care from the service had an authorisation in place from the Court of Protection, to lawfully deprive them of their liberty in a community setting.

We checked whether the provider was working within the principles of the MCA. We did not see any documentation as to whether a capacity assessment had been completed as this was not in the person's care file. The deputy manager told us capacity assessments were completed by people's case managers and they did not have this information. The manager requested all relevant capacity assessments from the relevant case manager on the first day of our inspection. The manager understood how to undertake best interest decisions. We found one decision had been made without a best interest meeting and the provider told us this was an oversight. We found other decisions about the persons care had been discussed in best interest meetings with the relevant people involved.

We recommend the provider reviews their application of the MCA to ensure that best practice guidance is followed and that appropriate documentation is retained about capacity assessments and any best interest decisions that are undertaken.

We asked staff about their knowledge of the person's capacity. Staff were not able to inform us about whether the person had capacity which meant staff were not aware whether the person was able to consent to their care. Information about the persons capacity had not been recorded in the persons care files. We discussed this with the provider who told us they would ensure information about the person's capacity would be included within the person's care file and that staff would benefited from further training. We discussed these recording issues within the well-led domain.

Not all staff were knowledgeable about the MCA. Some members of staff could not tell us about this although one member of staff had some understanding and told us, "People's capacity can be varied, some people need visual or role play to understand or have it written down to consent to or in object form. If I thought someone lacked capacity I would have a best interest meeting with social workers, advocates, nurses, doctors and possibly court to make a decision." We discussed the lack of knowledge from some staff with the provider who told us they would support staff with their knowledge of the MCA.

There was an induction programme for new staff which included shadowing experienced staff, group work,

a one-week training course and completion of the care certificate. This is a set of standards that social care and health workers follow as recommended by Skills for Care, a national provider of accreditation in training. The training lead told us improvements had been made and told us, 'We can now evidence a commitment to training that is far better than anything we've ever done before and demonstrates to staff that we are keen to support them and develop their skills.' The update of training had been in collaboration with the local authority using their organisation development team. They had been delivering training e.g. British Sign Language interpreting, but also giving appropriate deaf related examples to aid understanding. If they were unable to provide a particular training area they needed, the local authority signposted the service to potential training organisations they could use, or Homelife (Leeds) Limited staff would attend training sessions with interpreter support, which allowed staff to network with other service providers.

Not all training had been completed by staff and the training lead responsible for monitoring training needs used a matrix to monitor performance. We found the majority of staff had completed their medicines and safeguarding training. However, only 56% of staff had completed their DoLs training and 65% had completed MCA. The training leader had a planning tool which showed staff had been booked on to complete their training. The records of management meetings we looked had addressed the training issues and agreement reached for staff to be paid separately to attend training courses with the expectation this would improve attendance and ensure people's skills remained relevant.

Although staff were receiving supervision and appraisals, they felt the managers were too busy to provide support at times. We discussed the concerns raised by the staff with the deputy manager who told us, staff did receive supervisions. We checked three staff files which showed records of supervisions and appraisals having been completed.

The person using the service was supported with their nutritional needs. We saw staff supported the person during meal times to prevent the risk of choking. Instructions were recorded for staff to follow and we observed they ensured the person's seating, posture, support, food types and textured diet met their needs. For example, staff encouraged the person to use a specialised cup that only allowed 10ml of fluid during each sip to aid swallowing and prevent choking.

We saw health appointments had been arranged for the person using the service. However, annual health check forms in the care file had not recorded all of the outcomes. For example, the person's weights had not been recorded. We discussed this with the manager who told us the person had recently received an annual health check which had been satisfactory. On day two of the inspection their weight had been recorded. We found the provider had liaised with health care professionals involved in the person's care, these included, speech and language therapists, a psychiatrist, district nurses and dentists to support the person's ongoing physical and mental health needs.

We did find some examples where monitoring had taken place following input from health care professionals about the persons behaviours. For example, the person receiving care had their behaviours recorded and analysed to identify trends and themes. This information was then given to the person's psychiatrist to determine if this was related to mental health issues or their physical health so they could monitor for any deterioration and to determine the person's levels of support.

Good

Is the service caring?

Our findings

Staff told us they had positive working relationships with the person they cared for. We asked the person receiving care if their relationships with staff was good by showing them pictures of individual staff members. The person put their thumbs up to all staff confirming that they had no concerns with staff and that their relationship was good.

People using the service were deaf and therefore staff communicated using British Sign Language (BSL) to gain consent. Staff told us, "We ask [Name] for their consent before we do anything." We saw friendly interactions between staff and the person who used the service. We observed staff being patient and allowing time for the person to communicate their needs, when they felt able to.

Staff used individualised communication skill assessments to determine levels of dependency and support required from staff. This recorded how staff should communicate with people dependant on their abilities. For example, '[Name] to use all forms of communication available to them. Using BSL, writing using a white board or pen and paper, photo symbols. Formulate a visual timetable with [Name] to make it meaningful to them and encourage [Name] to use a white board so they could write or use British sign language to communication what they wanted to do.' This meant staff encouraged people to remain as independent as possible and to make decisions about their life.

Staff understood equality and diversity and we saw support was personalised to meet the person's individual needs. Staff were respectful and maintained people's dignity. For example, one care plan stated, "[Name] needs support to dress appropriately, weather dependent and to ensure their catheter is covered to reduce any embarrassment they may feel."

The person signed to tell us they were aware of their care plan and involved in reviews of their care. The provider made reasonable adjustments depending on people's needs to ensure they could communicate their preferences. The person using the service was unable to verbally communicate and had minimal sign language capability. They used an activities book that had visual aids to communicate the activities they wanted to do each day by pointing or holding the images.

Staff provided information and explanations to the person about their care and wellbeing in a way they would understand. For example, staff created a picture book with simple English to explain about the person's physical health condition. This helped the person to understand their condition and how this may change over time.

The person using the service did not have an advocate at the time of our inspection. One staff member told us the local authority had commissioned an advocacy service, which included advocates for hearing-impaired people.

We found care records were kept in a locked cupboard and staff were aware of how to keep information confidential. We did observe that the safe used to hold people's monies was kept in a storage area which

was often left open on the day we inspected. We addressed this with the provider on inspection who told us this would be locked if there were no staff in the office.

Good

Is the service responsive?

Our findings

We looked at the care plan for the person who used the service. The deputy manager told us the care plan was currently under review and said they had been working closely with the local authority to ensure it was person-centred and reflected the individual's needs.

There was a pen picture which informed staff about the person's life and helped them to get to know the person. The person's preferences had been recorded and we found staff knew their individual needs well. One member of staff told us, "We ask [Name] which side they prefer us to sit on and make sure we have eye contact. [Name] is also not confident in a group of people. When needing assistance with food [Name] prefers to eat privately, as they feel embarrassed eating in front of others and we support them to do this."

The person participated in a range of meaningful activities and reasonable adjustments were made so they could go on holiday. Due to the person's complex health needs, staff and the person had set a goal to go on holiday to Bournemouth. This was achieved and the person told us they enjoyed their time away. To prevent social isolation staff collaborated on a plan to ensure the person was kept safe whilst away which stated, 'Documentation must travel with [Name] in respect of their catheter and medicines to ensure that [Name] receives appropriate medical care should they become ill during the holiday. Staff need to talk to [Name] to help them understand the coach travel and activities whilst away. Staff need to ensure [Name] has farm foods ordered to take on holiday for their evening meals to ensure their nutritional needs are being met whilst away.'

We saw the person's interests and holidays had been recorded to inform staff about activities the person enjoyed. Some of the these included trips to Blackpool, Disneyland Paris and Bournemouth. The person told us they did a lot of activities which they enjoyed and this also meant the person was not isolated.

Staff ensured people were treated as individuals and supported them to make choices. One member of staff said, "I would give [Name] a few different options although not too many as this could confuse [Name]. I would limit it to two or three options for example, with food or clothes. I would do the same with information, give [Name] a little bit at a time to make sure [Name] understands what we are saying and can make a choice."

The deputy manager told us the staff were sensitive in their approach when addressing end of life care. The deputy manager said they had spoken with the person about their wishes and preferences for end of life care however, they did not wish to discuss this and staff respected their choice.

The deputy manager confirmed the service had not received any complaints in the last 12 months. They were able to explain what process would be taken should they receive a complaint. This included internal investigations, acting on safeguards, disciplinary actions taken if needed and communication with external services. The deputy manager also told us that should staff need to complain they used an application for mobile phones called 'Talk to us' where staff could email the managers directly to raise any concerns.

Requires Improvement

Is the service well-led?

Our findings

We found a lack of records to demonstrate actions had been taken to improve the service being provided. Staff had not always recorded when medicines had been administered. We found actions following incident and accidents had not always been recorded to show how the service may prevent future re occurrences. We also found MCA documentation had not been recorded in the person's care plan.

During the inspection, we requested information which took long periods of time to find because the management team were at times unsure of where certain information was stored. For example, the manager told us supervision records were stored at the head office. However, the director told us these were stored at the office based at the person's home. We found this to be disorganised.

We found a lack of effective governance systems to identify the shortfalls and to drive improvements. There was a lack of audits within the service to identify shortfalls we found at the inspection and to prevent re occurrence. We found recording issues on MARs which had not been identified because no medication audits had been carried out to monitor this. This meant potential errors or incidents were not being found due to the lack of auditing. Therefore, actions had not always been taken to improve practice and to show when lessons had been learnt to prevent re occurrences. There were no care plan audits to show the correct documentation relating to the person had been completed. For example, MCA documentation was not in the person's file and this had not been identified due to a lack of auditing. We discussed the lack of governance systems with the provider and they informed us that they were in the process of recruiting a team leader who will be responsible for ensuring governance systems are put in place.

During this inspection we informed the deputy manager that the CQC had not received the Provider Information Return requested prior to the inspection. The deputy manager told us this had been completed however the CQC did not receive this information.

The above concerns were a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was also the director of the service. Staff told us the registered manager was not always present and they felt a lack of support. There were mixed views about management and staff also told us there was an uncomfortable atmosphere within the team. We discussed this with the deputy manager as the registered manager was not available on day two of the inspection. The deputy manager told us they were aware of staffing concerns and that management were trying to address these in staff meetings, but staff said they did not always feel actions had been taken. Comments included, "They [The management] don't care. I'm not valued and the staff team don't work well, there are always issues" and "[The deputy manager] is good at managing the service."

Staff meetings took place on a monthly basis and we saw records of this. During the meetings staff discussed staffing levels, activities and trips away. Staff told us the registered manager and deputy manager had made some improvements, but felt that further support was required from the provider to improve the

quality of care. Staff said they had been open and honest in the past, raising concerns, but felt these were not managed. One member of staff told us they had suggested introducing medication audits due to the increase in recording issues however, this had not been acted on. We discussed this with the deputy manager during the feedback and said they would discuss any concerns with staff.

We saw monthly management meetings took place where records showed discussions took place about maintenance concerns that needed addressing, current ongoing care needs for people using the service and staffing issues. To improve the quality and quantity of audits and relationship between staff and the management, there had been an agreement to employ a team leader. They would be responsible for this liaison and ensuring quality checks were carried out. The director told us the new team leader had not yet started, but they hoped this would help to drive improvement within the service.

The provider carried out surveys to gather people's views. The most recent survey sent to relatives and health professionals had only just gone out when we inspected and the provider had received two responses so far. Comments included, 'All staff have been very helpful', 'Since [Name] has moved to Homelife [Name]'s hygiene is so much better', 'Since [Name] has moved with Homelife [Name] is much more confident, signs much better and is so much happier' and 'Friendly but with clear boundaries. Open and honest culture. Kind.'

The deputy manager told us the surveys for people using the service and staff were due to be sent out. The director told us information received from the surveys was summarised and fed back to the team. They also said if there were any concerns raised, for example, if someone said they didn't know how to complain, a meeting would be arranged to inform the person, staff or relatives how this could be achieved.

The service had a wide range of community links and many of these were specific to people's needs including deaf societies, social clubs for people with hearing difficulties and colleagues that could support people who were deaf. This meant the provider had actively made these links to ensure people using the service had access to a wide range of facilities to prevent social isolation and to support people to live their life.

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 The provider failed to follow systems in place to assess, monitor and improve the quality and safety of the service provided. There was failure to maintain accurate and complete records.