CareQuality Commission

Quality Of Life Homecare Limited

Unit 2 Watling Gate

Inspection report

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Colindale
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Date of inspection visit:
02 September 2016
06 September 2016

Date of publication:
15 November 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement

Summary of findings

Overall summary

We inspected Unit 2 Watling Gate on 2 September 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and the registered manager is often out undertaking duties associated with the service. We returned to the service on 6 September to obtain further information. We undertook this focused inspection as a response to concerns that we had received about the service in relation to staff recruitment and support, and the monitoring of care and safeguarding procedures.

During our previous comprehensive inspection of the Unit 2 Watling Gate in March 2015 we rated the service as good. We made one recommendation in relation to the introduction of formal medicines administration records.

We undertook this focused inspection in order to follow up concerns that we had received about the service in relation to staff recruitment and support, and the monitoring of care and safeguarding procedures.

Unit 2 Watling Gate provides domiciliary care services to people who live in the London Borough of Harrow. At the time of this inspection the service was working with 30 people, the majority of whom were receiving short term reablement support.

A registered manager was in place at 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.

Staff members were recruited in a way that ensured that they were suitable for the work they were undertaking in most cases. However, we were not satisfied that recruitment had always been undertaken safely. We were unable to see that references had been obtained for two staff members. We also found that the provider had not always sought criminal records and disclosure checks prior to staff being employed by the service. The records for two staff members related to previous employment.

We found that records of the on-going support that staff members received in their role were limited. Some staff members had not received recorded supervision and appraisal to ensure that they were competent in their roles.

The provider did not have formal processes in place to monitor whether or not care workers were on time and stayed the allocated time for their visits. Although some monitoring took place, there were limited records of this, particularly in relation to people who might be unable to say whether or not care visits took place appropriately.

Records of safeguarding concerns were maintained by the provider. These had been recorded appropriately

and reported to the local authority safeguarding team in a timely manner.

Appropriate records in relation to medicines administration were in place.

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 the full version of the 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

Aspects of the service were not safe. The staff records showed criminal records and barring information for two staff members were from previous employers. Two staff records did not contain references from previous employers.

Some staff members had not received regular supervision to ensure that they were competent in their roles.

Systems for monitoring care calls were limited.

Appropriate arrangements were in place for the recording of medicines.

Safeguarding concerns were appropriately recorded and reported.

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Unit 2 Watling Gate

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.

We undertook an announced inspection of Unit 2 Watling Gate on 2 September 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and the registered manager is often out undertaking duties associated with the service. We returned to the service on 6 September to obtain further information.

The purpose of this inspection was to follow up concerns that we had received about the service in relation to staff recruitment and support, and the monitoring of care and safeguarding procedures. The inspection was carried out by two inspectors.

During our inspection we looked at 16 staff files, three service user files and other records relating to the management of the service. We spoke with the registered manager, the service manager, and admin worker. Following the inspection we spoke with five people who use the service on the telephone.

Before our inspection we reviewed records that we held in relation to the service. We also spoke with two professionals from a local commissioning authority.

Requires Improvement

Is the service safe?

Our findings

People told us that the service was safe. One person said, "I feel very safe with them," and another person told us, "I look forward to seeing them. They always turn up on time and let me know if they are going to be late."

During our inspection we looked at the recruitment records for 16 members of staff. These were well kept and easy to access. The majority of these showed that safe recruitment practices had taken place to ensure that staff members were suitable for the work that they were undertaking, and included completed application forms, records of interviews, copies of identification documents and evidence of eligibility to work in The United Kingdom. However, we found that there were no references on file for two staff members

Criminal record and barring (DBS) checks had also been completed to establish that people were suitable to care for people using the service and, where the staff member had previously worked in another EU country the provider had sought criminal record checks in relation to this. However, we found that two staff records contained copies of DBS checks obtained by a previous employer. The registered manager told us that they hadn't applied for checks for these staff members as their previous DBS records were less than one year old. They showed us a copy of an application that had been made for a new DBS for one of these staff members. However, this had not yet been received. Our concerns about references and DBS checks meant that we could not be sure that all staff members had been safely recruited.

We also found that some staff members had not received regular supervision from a manager. There were limited records in place to show that competency in relation to safe practice was monitored and supported following staff members commencing work with the service.

Our concerns demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at care rotas and asked the registered manager about processes for monitoring care calls to people who used the service to ensure that staff members were on time and stayed the allocated time for their visits. We noted that there was no formal system for this. The registered manager told us that people signed staff time sheets each week to confirm that they had worked the required hours, and that they would usually call the office if staff their care staff were late. We were told that office staff called people regularly to check that they were satisfied with their care. However we did not see records of these calls. We asked about people who might not understand this procedure, for example, people living with dementia. The registered manager acknowledged that some of the people that they worked with would not be able to sign timesheets or call the office if they had a concern. The registered manager told us that they had been exploring the possibility of using electronic call monitoring systems, but that these might not always be appropriate for short term reablement contracts. However, they told us that they had would ensure that an effective call monitoring process was put in place.

We looked at the service's safeguarding records. These showed that safeguarding concerns had been

appropriately managed and reported to the local authority safeguarding team in a timely manner.

During our previous inspection of this service we had recommended that the provider consider improving their documentation in relation to recording of medicines administered to people by care staff. We saw that medicines administration records had been developed and were being used appropriately.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Satisfactory reference and criminal records checks were not always in place for staff members working at the service. 19(1)(2)