Copper Beech Homecare Ltd

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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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This was an announced inspection. We visited the provider's offices on the 5 January 2016 and made calls to people using the service and their relatives on the 7 January 2016. The last inspection was in June 2014 and the service was compliant with the regulations in force at the time.

Copper Beech Home Care Ltd is a domiciliary care agency registered for the regulated activity of personal care. The service provides care and support to people in their own homes. At the time of inspection there were 20 people using the service.

There was a newly registered manager who had been in post since December 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

We found that people's care was delivered safely and in a way of their choosing. People were supported in a manner that reflected their wishes and supported them to remain as independent as possible.

However not all recruitment records could demonstrate that the provider was following the correct process to recruit staff. The service did not consistently act upon and learn from accidents and incidents.

People's medicines were managed well. Staff watched for potential side effects and sought medical advice as needed when people's conditions changed. People and their family carers were supported to manage their own medicines if they wished.

Staff attended the provider's induction and training and people felt the staff were trained to meet their needs. Staff had the skills to meet people's needs. We found that formal supervision and appraisal processes were not fully established.

Not all people's care plans had been signed and consented to. It was unclear if people had agreed to their care. Arrangements were in place to request support from health and social care services to help keep people healthy. External professionals' advice was sought when needed. Families were consulted and felt involved. However it was not clear if the principles of the mental capacity act were followed when making decisions on how best to support people.

Care was provided by caring and attentive staff who took the time to get to know people and their families and support them in a manner of their choosing. People felt staff treated them with respect and kindness, taking to time to get them to know them as individuals.

People's needs were assessed prior to the service starting work with them. However care records and plans did not always contain the level of details required to help staff provide people with personalised care. There were inconsistencies in how records were kept and how they were reviewed by the service.

People and their relatives felt able to raise any concerns they had and felt the registered manager would respond positively. We saw that complaints were investigated correctly and actions taken to improve the service.

There was a newly registered manager in place who was open with us about the issues they had identified as needing to improve the service, but the quality assurance processes in the service had not identified some of the issues we found at our visit. There was a lack of critical review and robust learning from issues. The service had not acted upon feedback from a survey of people and relatives.

People and staff felt the registered manager was caring and supportive and they felt able to contact them for support or to raise any issues.

Summary of findings

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. Not all risk records were updated as people's needs changed. People using the service and their relatives felt safe and able to raise any concerns. Staff knew how to work in ways that kept people safe and prevented harm from occurring.

The staffing was organised to ensure people received appropriate support to meet their needs. Recruitment records did not always demonstrate that robust systems were in place to ensure staff were suitable to work with vulnerable people.

People's medicines were managed well. Staff were trained and monitored to make sure people received their medicines as required.

Is the service effective?

Requires improvement

The service was not always effective. Formal supervision and appraisal processes were not in place and had only just begun to occur. Staff attended the provider's induction and training.

Arrangements were in place to request support from health and social care services to help keep people healthy. External professionals' advice was sought when needed. Families were consulted and felt involved.

Staff had an awareness and knowledge of the Mental Capacity Act 2005, but the provider's records did not show how consent had been gained.

Is the service caring?

Good

The service was caring. Care was provided with kindness and compassion. People could make choices about how they wanted to be supported; staff listened to what they had to say.

People were treated with respect. Staff understood how to provide care in a dignified manner and respected people's right to privacy and choice.

The staff knew people well and took an interest in people and their family carers to provide individualised care.

Is the service responsive?

Requires improvement

The service was not always responsive. People had their needs assessed by the registered manager and staff knew how to support people in a caring and sensitive manner. However care records did not show the level of detail required to support people as individuals.

People could raise any concerns and felt confident these would be addressed promptly through the registered manager or office staff.

Summary of findings

Is the service well-led?

The service was not always well led. Systems were not in place to make sure the service learnt from events such as accidents and incidents. Quality audits of the service were limited in scope and lacked critical review.

Action had not been taken in response to surveys of people and relatives or to update the service's policies and procedures with current practice.

The people, relatives and staff we spoke with all felt the new registered manager was caring, approachable and person centred in their approach.

Requires improvement

Copper Beech Homecare 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 inspection took place on 5 January 2016 and was announced. We gave the service 48 hours' notice as it is a domiciliary service and we needed to be sure people would be available. The visit was undertaken by an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience telephoned people using the service, their families and carers on the 7 January 2016.

Before the inspection we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also reviewed information the provider has sent to us about their service, called a Provider Information Return. We also contacted local commissioners of the service for feedback. They had no concerns about the service.

During the inspection we spoke with three staff including the registered manager, four people who used the service and six relatives of other people who used the service. We also spoke with one external professional and had some written feedback from another who both had contact with the service.

Three care records were reviewed as was the staff training programme. Other records reviewed included, safeguarding adult's policies and procedures, and accidents and incident reports. We also reviewed five staff recruitment, induction, supervision and training files, and staff meeting records. The registered manager's action planning process was discussed with them as were their internal quality assurance process.

Requires improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe with the staff from the service, that staff arrived on time and stayed for their allotted time. However we found that records did not demonstrate that the service took appropriate action when risks to people occurred.

As part of the initial assessment before providing a service, a risk assessment including home safety assessment was carried out, usually by the registered manager. These assessments led to either planned reductions in risk or the creation of contingency plans to manage the risk. However, there had been an incident where a person had placed themselves at risk of injury whilst in the community with a staff member. An action plan had been started by the service to review this incident, but no subsequent changes or update had been made to this person's care plan, and the action plan remained incomplete five months later. This meant the person remained at risk of further repeat incidents and the services process for learning from such events was not consistently applied. We brought this to the registered manager's attention who agreed to take immediate action.

We looked at how staff were recruited and saw that the process was not consistent in that records were not maintained of the recruitment process. Staff we spoke with told us they had been subject to a formal application and interview process. Other checks were carried out, including the receipt of employment references and a Disclosure and Barring Service (DBS) check. A DBS check provides information to employers about an employee's criminal record and confirms if staff have been barred from working with vulnerable adults and children. This helps support safe recruitment decisions. Each recruitment record had a cover sheet which summarised what records the file was to contain. However in one record we saw that only one reference had been recorded and another staff member's references did not cover their most recent employment. Not all application forms had been completed fully. We found gaps in employment history and some forms that had not been signed by the applicant as a true record. We discussed these with the registered manager who advised the former registered manager had not always kept all records at the offices and they would seek to fill in any gaps in records. They had already identified this as an area for improvement since their appointment.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

One person told us, "I've never had a missed call and in fact I find the service to be very reliable." A family carer told us, "The carers who come to my relative always arrive on time and if they are running late it will only be a couple of minutes. We have never had any serious problems with the lateness of visits." Feedback from all people, relatives and external professionals was that the staff attended on time and kept them informed of any changes.

We saw that staff had attended safeguarding training as part of their induction. Staff we spoke with felt that safeguarding or other safety issues would be dealt with appropriately by the registered manager. All the staff we spoke with were aware of safeguarding adults and whistle-blowing procedures and felt confident to use these. They also felt confident that the registered manager would respond to any concerns they raised. Staff told us that keeping people safe was a core principle of their work.

We looked at how staff were kept safe. Staff often worked alone in people's homes for long periods but had contact numbers for out of office hours in case of emergencies. We saw out of hours support had been used once and action had been taken following the incident to avoid a repeat occurrence. The service did not have a robust contingency plan in place for a major event, such as fire at the office. The newly appointed registered manager agreed to take immediate action to rectify this so there was a clear process in place for such events.

We looked at how medicines were managed. Some people had family carers and as part of the initial assessment agreement was reached about how medicines would be managed. Where people or their relatives chose to manage their own medicines this was risk assessed and kept under review. Where the service had responsibility for medicines, the administration of these was carried out by suitably trained staff. Staff who handled medicines had attended the provider's training and regular refresher courses. People told us staff supported them to take their medicines as they wished. One person told us, "My hands really won't let me do anything these days so it is easier for my carer to be able to take my tablets out of the Dosette box and give them to me. She makes sure she writes in the records to say that I have taken them as my mind can play tricks with me these days and I sometimes wonder whether I have taken

Requires improvement

Is the service safe?

them or not if she wasn't here to do that for me." Dosette boxes are containers that you can fill yourself, or with assistance from family and carers. These have separate compartments for days of the week and / or times of day such as morning, afternoon and evening. Another person told us that a carer had noticed another carer had missed a medicine. They reported this and the correct procedure was followed to prevent re-occurrence. However we found one person's care plan did not detail their medicines. We discussed this with the registered manager and a staff member, who told us records in the home were complete. The registered manager had identified that care plans in the office needed updating to be in line with people's needs and had already started to take action to update these.

Staff told us they had all attended appropriate infection control training, and that the service always ensured that disposable gloves and aprons were supplied to the person's home for their use.

Requires improvement

Is the service effective?

Our findings

People told us they felt the service was effective. However we found that records confirming people, or their representatives had consented to their care plan were not always completed.

We saw that some people using the service did not have the capacity to consent to their care. We saw that one person had a lasting power of attorney (LPA) appointed (a legal tool that allows you to appoint someone to make certain decisions on your behalf). Their care plan had not been signed by either the person themselves or their LPA so it was unclear if the service had gained their consent. Other care records had also not been signed by the person so it was unclear if they had agreed to or consented to their care plan. We brought this to the registered manager's attention who agreed to gain these signatures and consents. People and their relatives we spoke with told us they had been involved in the creation of their care plans and were part of any reviews. They had felt able to make changes to these plans over time.

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. We saw records in care plans of discussions between families and external professionals about how to care for people who had lost their capacity. These did not always follow the principles of the MCA so it was not clear if decisions had been made in the person's best interests.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff induction, training, supervision and appraisal files. We saw there was day to day contact with staff where the registered manager visited or called people and spoke with staff. However when we looked for records of formal induction, supervision and annual appraisal of staff we found that these had not been recorded. We spoke to staff who told us they had undertaken induction training and could contact the office for support or attend team meetings, but that regular supervision and appraisal had not been taking place. We talked to the registered manager about this who had identified this support had not been given in the past. They told us they had made arrangements for this to start.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other records around training showed us that staff had attended the training needed to perform their work. The registered manager told us they had accessed end of life, learning disability and epilepsy training for staff to support particular people. People and relatives we spoke with felt the staff were trained to meet their needs. One relative told us, "(Name) has various pieces of equipment that we have to use these days because of their disability and I have to say that the carers are very competent with using these and making sure that (name) feels safe when they are assisting." Another person told us, "For what it is I need doing, I think the carers are adequately trained. I certainly haven't had any issues regarding their training."

We saw that staff supported people to eat and drink, helping them maintain skills in the kitchen if possible by working alongside them. One relative we spoke with told us staff did all the cooking and meal preparation for their relative who lived alone.

We saw from records that people had access to support from health care professionals including GP's, district nurses and occupational therapists. There was evidence in care plans and other records that the staff were proactive in requesting occupational therapist input where people needed equipment installed in their homes for their safety. From our discussions and a review of records we found the service had developed good links with other health and social care professionals to help make sure people received prompt and co-ordinated care.

Good

Is the service caring?

Our findings

People and their relatives told us they felt the staff cared for them well. One person told us, "I suppose I am quite set in my ways and I like things to be done the way I like them. I have to say my carers are very good at putting up with me in that respect. I'm never made to feel like a number."

Relatives we spoke with also agreed. One told us, "My (relative) has to be hoisted and it's not something that they really look forward to, but I have to say the carers always make sure they are well covered up and that the curtains are closed so that no one can see what is taking place. I know it's only a small thing but this is really important to my (relative)."

People and relatives told us the staff approach was caring and courteous at all times. People told us they felt staff respected their privacy and confidentiality. For example one person told us, "I've never heard my carer talk about any of their other clients in front of me and I would be horrified if that was happening. We often talk about what has been happening on the news or what I have been up to during the day, but my carers never talk to me about any other clients." Another person told us, "At the first meeting, the manager asked me how I like to be addressed and I told them that my first name was just fine. My carers always call me by my first name and I would hate it to be any other way. I really can't stand being called (Title) so it is really important to me that my carers call me by my first name especially when they are doing really personal things for me."

Some of the records did not contain much detail about the people they were supporting, but the feedback from people and their relatives was that staff asked about their lives and showed real interest in their wellbeing. They told us that staff checked with them for permission before carrying out care tasks and respected their choices. For example on person told us, "My carer doesn't rush me with anything but will usually allow me to take my own time to get organised as I am a bit slow these days. They will never start doing anything until I am ready though."

From talking to staff it was clear they had the skills to meet people's care needs, and they saw part of their job as being to get to know people well and provide emotional support. From talking to the registered manager she was clear the ethos of the service was not just about providing care, but supporting people through giving them choice and respecting their decisions.

People told us that when they contacted the office someone would call them back promptly if no-one was able to speak to them straight away.

External professionals we contacted commented they gave positive feedback about the caring nature of the service. One told us, "They have taken work on and keep us updated if there are any issues. The feedback I have had has been good to date."

Requires improvement

Is the service responsive?

Our findings

People told us they thought the service was responsive to their needs. However we found that care records were not always comprehensive enough to demonstrate how care was delivered.

People and their relatives told us they had been involved in the creation of the original care plan before the service started working with them. One person told us, "Before we started with the agency a manager came to visit us. They explained what it was the service could offer us and talked about how the visits were organised. We then talked about what assistance we needed and the times of day we would like the visit to happen. We were impressed that they were very open with us and they have certainly delivered on what they promised too, which is a good deal better than other agencies have done in the past."

The care records we looked at did not always contain all the details needed, such as contact telephone number for people's GP's and other key contacts. Other records did not describe care in the detail needed for it to be delivered consistently. For example we saw that one person's relative had asked for a drink of water to be placed next to their relative's bed at night. This information was not included in their revised care plan. Some records and care plans were not dated so it was unclear when they were due for review. Some moving and handling care plans were vague and lacked specific details about how people should be supported. Reviews of care were also limited; there was little change to records over time and it was not clear if people had been consulted as part of the review process. We discussed this with the registered manager who had already identified the need to improve care plans and told us they would be taking action to improve care records.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that if new staff were coming to support them they would be told in advance. One staff member told us that sometimes they did not know who they would be seeing until short notice, but felt this had improved since the new registered manager had started. One relative told us, "The agency will usually ring me if there needs to be a change in the carer, which is usually only when either one of (relative's) carers goes ill or they are going off on holiday."

People were supported to remain as independent as possible in their own home. We saw that staff had clear knowledge of their likes and dislikes, routines and habits. This knowledge helped them support the person who had lost mental capacity. We saw the staff recorded what activities they had done each day with the person in some detail, explaining how they had supported them and suggesting ways to further engage with the person.

People and their relatives told us they knew how to raise concerns or make a complaint. One told us they had asked for another carer to be provided and the office staff arranged this without question. Another person told us, "There is a leaflet about how to make complaints in my folder because the manager talked us through this when we first met up with them. I haven't had to make complaints at all though but I think from my dealings with the agency so far that they would listen if I had any problems that I wanted to sort out with them." Other people and relatives we spoke with felt the new registered manager would listen to their concerns and responded quickly to them. We saw there had been one complaint about a staff member in 2015. This had been investigated and responded to appropriately by the provider. We also saw the service had received two compliments which highlighted recent positive changes made.

Requires improvement

Is the service well-led?

Our findings

People told us they felt the leadership of the service had improved since the new registered manager had been appointed. However we found a number of issues which had not been acted upon by the service. The newly appointed registered manager was open with us about some of the areas they wished to improve further, but there were some issues they had not identified until we drew them to their attention at our visit.

We found that some of the provider's policies and procedures needed to be updated or improved. For example the provider's safeguarding adult's policy needed to reflect the reporting procedures for the local authority. The service undertook a survey of people using the service in 2015, but these were of limited use and had not led to a response to any of the issues raised. The surveys had been sent to people and relatives but some of the questions were open to differing interpretation. The provider had not reviewed these findings to identify if there were any learning points or taken any clear action following this survey. There had not been comprehensive review of all accidents and incidents and some post incident review documentation had not been completed. Processes and records relating to staff supervision, induction and appraisal had not been put in place to support staff.

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

People and their relatives we spoke with all felt the registered manager was open and approachable. One person told us, "(The registered manager) is really nice and will usually phone me up at least once a month to make sure that everything is going alright with my care. She is very approachable and I would not hesitate to pick up the phone to her if I had any concerns about my carers." A relative also told us, "(The registered manager) has been really good, taking the time to contact me to find out how my (relative) is. They even called when they were in hospital to enquire about them."

Staff we spoke with told us the registered manager was approachable, knowledgeable, caring and always there to support them. They told us they could contact them when they needed support. We saw meeting notes where the registered manager met with staff to discuss changes to the service and seek some feedback. However the provider had not undertaken a survey of its staff so it was unclear how they formally gauged their views or ideas for improvement.

We discussed notifications to the Care Quality Commission (CQC) with the registered manager. They were clear about their role as a registered person and had sought advice previously from the CQC to ensure they were meeting their statutory requirements. They clearly articulated the areas they wished to improve and were open and transparent with us, providing any documents requested.

The registered manager explained their quality assurance process of reporting to the Directors. This included a weekly report covering areas such as hours worked; accidents and incidents; pressure areas and number of enquiries. They agreed this needed further review to include areas they had identified as needing improvement, and how they would monitor this improvement over time. This way they would be able to demonstrate how they used the process to develop and improve the service further.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17: Good governance. The registered person had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Records relating to people employed had not been created, amended and stored in accordance with current legislation and guidance. The registered person had not acted on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; Regulation 17 (2) (a) (b) (d) and (e)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11: Need for consent. The registered person had not ensured that care and treatment of service users was provided with the consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 18: Staffing. The registered person had not ensured that staff received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9: Person-centred care The registered person had not ensured that care or treatment was designed with a view to achieving service users' preferences and ensuring their needs are met. Regulation 9 (3) (b)