Firstpoint Homecare Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
● Firstpoint Homecare Limited is a community based care provider that provides personal care and support to people in their own homes. At the time of our inspection there were 164 people receiving personal care.

People's experience of using this service:
● People were not always protected from the risk of harm. Conflicting, out of date and unclear risk assessments placed people at risk of receiving unsafe or inappropriate care as staff did not always have sufficient guidance to follow. Medication records were not filled out correctly and therefore we could not be assured that people had received their medication as prescribed. Systems in place to monitor call times were not effective and people did not consistently receive their calls at the times needed and on occasions did not receive a call at all. There were insufficient staffing levels at weekends which impacted on the quality and safety of the service. Care staff did not consistenly follow good infection control practices and this placed people at risk of cross infection. The provider had a recruitment process to ensure the appropriate checks were carried out when recruiting staff.

● People's needs were not always accurately reflected in their care plans. Staff did not always receive the appropriate training they needed to meet people's individual health needs. People did not always receive their food and drink at the correct times as calls were not always on time. People were not always supported by regular staff, care was inconsistent. The provider did not always work within the principles of the Mental Capacity Act 2005. People's religious and cultural beliefs were respected. People told us that their regular carers knew them and how to support them.

● The provider's systems did not always support the service to be caring as people were unsatisfied with the management of their call times and how their concerns were managed. Some people told us care staff were kind and caring whilst others' views were not so positive. People's dignity was not always respected. Staff promoted independence.

● People and their relatives told us they did not feel the provider listened to their complaints or concerns. Care records were not updated to reflect people's current support needs. They were not always accurate and lacked sufficient detail to determine what peoples' specific needs were. We found the provider's systems did not always support the service to be fully responsive as people did not always receive their care calls at their preferred time and/or experienced missed calls.

● The provider did not have effective governance or audting systems in place to ensure that people received safe care and treatment. Governance and oversight systems had failed to ensure risk assessments provided sufficient guidance to staff to ensure people received safe care. There was no robust system in place to ensure risk was appropriately managed. The provider did not have sufficient oversight of training to ensure care staff had specialist training to support people's individual needs. The provider's infection control

systems were not effective and meant people were being put at avoidable risk of cross infection. The provider's call monitoring system was not effective in ensuring people received their calls at the time they required them. The provider did not have an effective system in place to monitor missed calls. The provider's scheduling system did not give care staff enough travel time in order to arrive at service users calls at the scheduled times. The providers on-call system was not effective. There was a lack of oversight of safeguarding concerns. There was no registered manager in post as required by law.

Rating at last inspection:
● Rated requires improvement overall (report published 16/05/2018). For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Why we inspected:
● This was a planned inspection based on the rating from the last inspection.

Enforcement:
• Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up:
● As we have rated the service as inadequate, the service will be placed in 'special measures'. Services in special measures will be kept under review and, if we have not already taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe, so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. For adult social care services, the maximum time for being in special measures will usually be no more than12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our Effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our Responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Firstpoint Homecare Ltd

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 checked 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.

Inspection team:
The inspection was carried out by an inspector, two assistant inspectors 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.

Service and service type:
Firstpoint Homecare Limited is a community based care provider. The Care Quality Commission regulates the care provided. The service did not have a manager registered with the Care Quality Commission as required by law.

Notice of inspection
We gave the service 48 hours notice of the inspection site visit.

What we did:
Prior to the inspection we reviewed information we held about the service since their last inspection. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted a number of local authorities who commissioned services from this provider.

During the inspection process we spoke with seven people, thirty four relatives, seventeen members of staff, the registered manager and the provider.

We looked at the care and review records for eleven people who used the service and four staff files. We looked at recruitment and training files. We looked at records for how people were administered medicines

as well as a range of records relating to the running of the service. This included incident and accident monitoring, auditing systems and complaints.

Inadequate

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

- Risk assessments contained conflicting information. For example, one person's risk assessment contained conflicting information about what foods were safe for them and the current level of risk was unclear. Conflicting and unclear risk assessments placed people at risk of receiving unsafe or inappropriate care as staff did not always have sufficient guidance to follow.
- We identified several people who were at risk of choking. Care plans did not include health professional's reports or guidance to ensure that people were receiving the correct level of care to support them safely.
- There was no guidance in place for staff on how to mitigate risks associated with choking and what to do in an emergency situation.
- Risk assessments did not always contain sufficient information to guide staff on how to support people safely. For example, one person required thickener in their fluids. There was no information on how much thickener was to be used to ensure this person's fluids were at the correct consistency. Another person required hoisting but no information was given to guide staff on how to do this safely. One member of staff said, "If the clients were not able to tell me, I would struggle to know what to do." This put people at potential risk of harm.
- Risk assessments were not always up to date. For example one care plan was last updated over a year ago and contained details of the person's medication that was out of date. This meant staff did not have the correct information to support people's current needs. A relative told us, "My mum has a care plan, but it is never reviewed or updated. I don't think they even know what is written in it."
- Staff were sometimes asked to support people without the correct training. This placed people at potential risk of harm. For example, feedback we received from people and care staff confirmed they had been asked to support people with a stoma bag when they had not received any training in this area. One relative told us how they were worried about lack of training in specialised areas. They said "[Person who used the service] commented they felt frightened that staff would not recognise when they needed help due to their health condition and what action to take." One staff member told us, " I had not had any training in stoma bags. I had to go and help a person with a stoma bag, had the client [person who used the service] not been able to tell me what to do, I would not be able to help. The office did not tell me the person had a stoma."
- During the inspection, we were made aware of one safeguarding concern which the manager had dealt with alongside the local authority, however, records had not been kept to evidence what actions they had taken to keep people safe.

Using medicines safely

- Medication records were not completed correctly and we identified gaps where staff should have signed to confirm they had administered medication. We, therefore could not be assured that people had received their medication as prescribed. The manager told us they did not completed audits of medication records

and so could not assure us that people had received their correct medication. One relative told us, "I would not trust the staff to administer medication." One staff member said, "We are supposed to be spot checked every three months, I had one just, the one before was six months. Additional training would be useful. Last time I was spot checked the client did not have medication so I was not checked."

Systems and processes

● Systems in place to monitor call times were not effective. People told us they often received late calls or calls that were too early which impacted negatively on people's lives. One relative told us how this meant her mother could be left in soiled incontinence wear for many hours placing their skin integrity and dignity at risk. One person needed time critical calls due to their health condition and did not always receive calls on time putting them at risk of potential harm. Another relative told us and records confirmed that their mother should have a morning call but sometimes these calls could be as late as lunchtime. The relative told us, "I am worried my mother will have an accident." (trying to get themselves up and ready for the day unaided).

● Call monitoring systems were not effective in identifying if people had received their calls as scheduled or whether they had been missed. Records we observed showed many calls which had not been logged in and out of and staff were not able to tell us whether these calls had been carried out or not. We could not be assured that people had received the support they needed to keep them safe. One family member told us their relative often received calls either too early or too late and sometimes didn't receive a call at all. They said, "There has to be change, I can see a tragedy coming along. I just want [person] to be safe."

● People and staff we spoke with told us missed calls happened. The provider had no system in place to monitor and record missed calls. A family member told us how their relative had not received calls over an entire weekend and family had to step in to support. One staff member said, "Clients are missing calls."

● Systems for scheduling call times for staff were not effective and staff often did not get any travel time between calls which meant they were late for calls. Records we observed confirmed this.

Staffing levels

● There were insufficient staffing levels at the weekend which meant that people did not receive their calls on time and sometimes did not receive a call at all. One family member told us how they supported their relative themselves as their calls were time critical. This meant they could not wait for the provider to find staff to support them. One staff member told us they were asked to support a person alone when there should have been two care staff to support because the on-call team could not find another member of staff to help. This meant that both the person and the staff member were put at risk of potential harm.

● There was insufficient staff managing the on-call system over the weekend and both people and staff we spoke with told us they were often unable to speak to someone when they needed help and advice. One staff member told us, "At weekends, on-call is not very helpful, can't get through, won't answer the phone."

● There were insufficient numbers of senior staff to support and supervise care staff whilst working at people's homes in order to monitor and ensure they were providing safe care and treatment to people in their own homes.

Preventing and controlling infection

● Whilst care staff did receive training in infection control during induction, feedback we received from people and their relatives told us that staff did not always follow good infection control practices which put people at risk of cross infection.

● One person told us how care staff had used the same pair of gloves after completing personal care to make a drink. They said, "I had to tell them [staff] it was unhygienic, it was not acceptable after taking me to the bathroom for them to have the same gloves and offer me a drink.

● One relative told us that care staff had come into their mother's home and had not removed their coat

and cap they were wearing and started to prepare food without washing their hands.

Learning lessons when things go wrong
● The provider was aware that people were dissatisfied with their call times and had employed a new member of staff to monitor the call logging in and out system. There had been some improvement when we inspected, however, not enough progress had been made to ensure people received their calls consistently at their required times.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

● Since our inspection the provider has been asked to to re-assess people's care plans and risk assessments to ensure they are up to date, contain sufficient information to support people safely and reflect people's current needs.
● Some risk assessments contained sufficient information and guidance on how to support people safely but this was not consistent. A care plan and risk assessments we observed on the new electronic system contained detailed information on how to support the person safely.
● Care staff received training on how to recognise the signs of abuse and who to report their concerns to.
● The manager was aware that there was insufficient staff at weekends and was actively recruiting. The manager had re-organised the staff team and had brought in new staff to improve scheduling and call monitoring.

Inadequate

Is the service effective?

Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes.

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

- People's needs were not always accurately reflected in their care plans. People told us regular staff knew people's needs well, however, new staff did not know what people's care needs were.
- People's religious and cultural beliefs were respected.

Staff skills, knowledge and experience

- Staff did not always receive the appropriate training they needed to meet people's individual health needs. One person told us, "They have no training. Two new care workers came and neither of them had ever changed a stoma bag. They both went outside and had a look on their phones on YouTube at how it was done and then came back in and changed it. When I asked them they said they were not told they had to change a stoma bag and they had no training in these matters."
- People told us that their regular carers knew them and how to support them.
- Staff received induction training when they first started work. The Care Certificate standards were included in the induction process. The Care Certificate is the nationally recognised benchmark set as the induction standard for staff working in care settings.
- There was a training matrix which evidenced what training staff had received.
- Staff received refresher training each year, however we found that staff did not always put their training into practice, such as regarding infection prevention.

Supporting people to eat and drink enough with choice in a balanced diet

- People did not always receive their food and drink at the correct times as calls were not always on time. This meant people could go for long periods without food or drink.
- People's care plans did not give sufficient or accurate information on what people's dietary needs were and we could not be assured that they received their food and drink as needed and in a safe way. Some staff we spoke with told us which people required a specialised diet, however, one member of staff we spoke with told us a person had a normal diet when in fact they should be on a modified diet.

Staff providing consistent, effective, timely care within and across organisations

- People and staff told us and records confirmed that calls ran late or were missed completely. One relative told us, "I asked them [staff] not to come again because about 60% of the time they [staff] did not turn up. I have missed hospital and GP appointments due to being let down by the service and being unable to leave my mother."
- People told us and records confirmed that people did not always receive regular care staff. One person told us, "I have had over 30 different care workers in 12 months. I find it a bit overwhelming." One person's

records we looked at confirmed they had received 21 different care staff in the last four weeks. People told us they were constantly having to tell care staff what support they required as staff did not know them.
● Some people we spoke with told us that they did have regular care staff and they were happy with these staff.

Supporting people to live healthier lives, access healthcare services and support
● There was no information in people's care plans to show that people were supported to access healthcare services. One relative told us, "Firstpoint have never asked to see any speech and language assessments or any other assessments."

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.

● The provider was not consistently working within the principles of the MCA. Where people did not have the capacity to consent the appropriate authorisations were not always in place. For example, within one person's care plan a family member had signed the consent to care on behalf of the person. No best interests decision had been recorded to evidence that this decision was made in the person's best interests. There was no lasting power of attorney for health and welfare on file to show the relative could sign on this person's behalf. However, some care plans we observed confirmed that a lasting power of attorney was in place for people.

● Staff had received training in the Mental Capacity Act. They could tell us how people should be allowed to make their own choices and how they would ask for consent.

Requires Improvement

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

RI:□People did not always feel well-supported, cared for or treated with dignity and respect. Regulations have been met.

Ensuring people are well treated and supported

● We found the provider's systems did not always support the service to be caring. For example, people told us they were not always satisfied with the management of their call times and how their concerns were managed. One person commented, "The girls themselves [care staff] are really good, they just don't have the back up support from the office."

● People's views on how they were treated varied. Some people told us they had really good regular carers whilst other people told us that they were not always treated well.

● One person told us, "I don't feel like a person being looked after, I feel like an object or an animal."

● Another person said, "I am happy with them [care staff], I will not have a word said against them."

● One relative said, " The normal carers are excellent but I was concerned about carers on a Wednesday when normal carers were on training. Not happy with them, their attitude. I do not think that these carers would have prepared food for [person who used the service] correctly if I wasn't there. English was limited for one carer and the other carer was rude. Carers were throwing [person's] mirror across them over the bed and laughing. [Person] was upset."

● Another relative told us, "Care ranges from satisfactory to at best a bit piecemeal. [Person who used the service] gets on well with usual carer but when this lady is not available the system falls down. Care is not as good as I would expect."

Supporting people to express their views and be involved in making decisions about their care

● Whilst most care plans we sampled were not up to date, where people's care plans had been reviewed, records showed that people had been involved in planning their care.

● People and relatives we spoke with told us they did not feel listened to. Several people said that they had asked many times for a rota and that one had not yet been produced. People indicated that it was difficult when they didn't know who was coming into the house.

Respecting and promoting people's privacy, dignity and independence

● Staff we spoke with told us how they would respect a person's privacy and dignity. One staff member described how they would shut the door and close the curtains whilst supporting with personal care and cover a person with a towel whilst sat on the commode.

● Care staff told us how they would support a person to maintain their independence. One staff member told us, "I will allow the person to do what they can. For example bathing, I will say do what you can do and I will do the rest."

Inadequate

Is the service responsive?

Our findings

Responsive – this means that services met people's needs

Inadequate: Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Improving care quality in response to complaints or concerns

- People and their relatives told us they did not feel the provider listened to their complaints or concerns. One person told us, "I had to meet with the manager and Social Services to hear my complaint. It just didn't work as the manager was looking at their watch all the way through. It made me feel very unimportant as though it was too much trouble to listen to my concerns."
- One relative forwarded a complaint they had raised with the council as they had failed to receive any communication from their initial complaint to the provider.
- Another relative told us how they had tried to complain as the person had not received their care call on numerous occasions. They said, "When I phoned Firstpoint they said, "You'll have to phone back in half an hour then when I phoned back they [staff] said I would have to phone back in another half an hour. They [staff] did not provide the service and would not provide the complaint procedure because when I requested this they [staff] hung up on me."
- We looked at the provider's complaints records. One complaint we sampled showed us that a person had requested a review of their care in June 2018. This had still not been carried out in February 2019. The manager went out to review this person's care and agreed a follow up review as the person was waiting for a new piece of equipment. When we spoke with the manager, they confirmed they had not completed the follow up review as agreed.
- An email the manager had sent to staff in May 2018 states, "The amount of complaints coming in is beyond a joke – Please do your job so I don't spend the whole day following up complaints with your clients!"

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 receiving and acting on complaints.

Personalised care

- Care records were not consistently fully completed, accurate and kept up to date. We found care plans lacked sufficient detail to determine what peoples' specific needs were in relation to key areas such as nutrition, mobility and equipment. Conflicting information contained in care plans and care plans that were not updated meant that staff were not always provided with the information they required to deliver personalised care.
- We found the provider's systems did not always support the service to be fully responsive. For example, people did not always receive their care calls at their preferred time or at the agreed time and/or experienced missed calls.

End of life care and support

● Care plans we sampled did not contain any end of life care plans and this meant that people's wishes, values and beliefs may not be considered at the end of their life.

Inadequate

Is the service well-led?

Our findings

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Leadership and management

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong

- The provider did not have effective governance or audting systems in place to ensure that people received safe care and treatment. After asking repeatedly for audits on the day of inspection, the manager told us they had to be honest, that they had no audits of the service.
- There were no audits to monitor medication administration records to ensure people received their medication as prescribed. The provider could, therefore, not be assured that people had not suffered any impact to their health as a result.
- There were no audits of daily logs to effectively monitor the care that people received was in line with their care needs.
- There were no audits to ensure care plans were up to date and reflected people's current needs.
- Governance and oversight systems had failed to ensure risk assessments provided sufficient guidance to staff to ensure they received safe care and they contained conflicting information. There was no robust system in place to ensure risk was appropriately managed.
- There was a lack of oversight of equipment to ensure it was used safely. Risk assessments did not consistently contain enough information for staff on how to correctly use a piece of equipment to transfer a person safely. There was no oversight of how to safely manage different equipment care staff may be required to use during the course of their work. This put both people and staff at risk of potential harm.
- The provider did not have sufficient oversight of training to ensure care staff were not sent to support people with specialist needs when they did not have the appropriate training.
- The provider's infection control systems were not effective and meant people were being put at avoidable risk of cross infection.
- The provider's call monitoring system was not effective and people did not consistently receive calls at the time they required them.
- The provider did not have an effective system in place to monitor missed calls. Feedback from people and their relatives consistently informed us that calls were missed.
- The provider's scheduling system did not give care staff enough travel time in order to arrive at people's calls at the scheduled times.
- The provider's systems and processes failed to ensure the quality and safety of the service at all times and to ensure incidents and safety concerns were investigated and learned from as far as possible.
- The providers on-call system was not effective and people were unable to get through when they needed help and support and often received a voicemail.
- The provider was aware of their responsibilities to notify the Care Quality Commission of any safeguarding concerns, however, we identified one safeguarding alert which the provider had not informed us of as

required by law. We discussed this with the manager who told us they did not realise they had to notify us of this particular incident because the case had been closed and the issue dealt with.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements

● There was no registered manager in post as required by law. In the last 12 months there have been three managers in post, none of whom had registered with the Care Quality Commission. This indicates inconsistent management and leadership at the service.

Engaging and involving people using the service, the public and staff

● There were no effective surveys or questionnaires for people to give their views on the service and people, relatives and staff repeatedly told us they were not listened to. On relative told us, "If I ring the office, if they answer at all, they say they will ring back but they never do."

● A client satisfaction survey was carried out by the provider in July 2018 but was only sent to 51 people. The provider had 14 responses. There was no evidence of any action taken after receiving people's feedback to improve the quality of the service.

Continuous learning and improving care

● The provider had been operating a new call monitoring system to try and improve their call schedules, however, this was not currently effective. The provider had introduced a new electronic system to store people's records and they told us this will keep care plans up to date and improve the quality of the service. This was not yet embedded in the service.

● Our last inspection of the service in May 2018 rated the service as requires improvement. The provider did not have an action plan in place to evidence how they intended to address the concerns we raised and how they were going to improve the quality of the service.

Working in partnership with others

● The provider is currently working with an action plan in conjunction with Solihull Council to address some of the concerns mentioned in the report. Feedback from people, relatives, staff and records confirm that progress has not been sufficient enough to improve the quality and safety of the service.

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