Home from Home Care Services Limited

Home from Home Care Services Limited - 168 Burton Road Derby

Inspection report

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Date of inspection visit:
13 June 2016

Date of publication:
21 July 2016

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**

Summary of findings

Overall summary

This inspection took place on 13 June 2016 and was announced. We gave the provider 48 hours' notice of our office visit. This was to make sure that there would be someone in when we visited.

Home from Home Care Services Limited - 168 Burton Road Derby provides personal care to people in their own homes in Derby. This included people living with dementia, older people, people with mental health and physical disability. At the time of this inspection there were 90 people using the service, which included 63 people who received personal care.

There was a registered manager in post; they were also the service provider. The registered manager was not based at the Derby office. Office staff told us the registered manager visited the office a couple of times each month. 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 our previous inspection on 24 July 2014 the provider was not meeting all the regulations that we checked. We asked the provider to make improvements to care records as they were either not in place or were not kept up to date. At this inspection we found that some improvements had been made and care plans were up to date. However, some care plans did not provide specific guidance for staff about how to provide care to meet people's needs in the way they required and preferred.
Whilst staff told us that they felt supported by the office manager and coordinators, the leadership and management of the service and its governance systems were not robust. Systems to monitor and review the quality of some areas of the service people received were not in place.

People using the service and relatives told us they felt safe. Staff we spoke with understood their responsibility in protecting people from the risk of harm, however we had not been notified of all incidents of a safeguarding nature. Overall, staff were available to cover care calls, however care was not always provided at the agreed times and in a consistent way.

Recruitment procedures were not thorough. For example not all the required pre-employment checks were completed. This did not provide assurance suitable staff were employed to work with the people who used the service.

The provider did not fully understand their responsibilities under the Mental Capacity Act 2005. Staff were not clear about people's individual capacity to make decisions.

Complaints were not always well managed and communication with the office had been inconsistent and not resolved issues satisfactorily.

People told us that staff treated them in a caring way and respected their privacy and supported them to maintain their dignity.

We found a 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

The service was not always safe.

People told us they felt safe. Staff knew how to recognise and report potential abuse, however we had not been notified of all incidents of this nature. The deployment of staff was not always effective and care was not always provided at the agreed times and in a consistent way. Recruitment procedures were not thorough to ensure risks to peoples safety was minimised. Overall, staff supported people to receive their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff felt confident to fulfil their role because they felt they received the relevant training. The provider and staff were not always aware of how to protect the rights of people who needed support to make decisions. People were supported to eat and drink enough to maintain their health, and staff monitored people's health to ensure any changing health needs were met.

Is the service caring?

Good

The service was caring.

People were supported by staff that were kind and caring. People's privacy, dignity and independence was respected and promoted. People and relatives were involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were involved in planning their care, however some care plans did not provide specific guidance for staff about how to provide care to meet people's needs in the way they required and preferred. People were not confident that any concerns they raised would be listened to and action would be taken.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had a registered manager in post; however they were not involved in the day to day management of the service. Governance and quality assurance systems were not effective in determining the quality of the service provided and developing plans to bring about improvement.

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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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 13 June 2016 and was announced. The provider was given 48 hour's notice because the location provides a domiciliary care service and we needed to be sure there would be someone in when we visited. The inspection was carried out by one 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 did not attend the office base of the service, but spoke by telephone with people who used the service and relatives of people that used the service.

We reviewed the information we held about the service, which included notifications. Notifications are changes, events or incidents that the registered provider must inform CQC about. We contacted commissioners and asked them for their views about the service. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with five people who used the service and seven relatives. We spoke with the office co-ordinator, staff co-ordinator, administrative assistant and five care staff.

We reviewed records which included two people's care records to see how their care and treatment was planned and delivered. We reviewed three staff employment records and other records which related to the management of the service such as quality assurance, staff training records and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with the staff that supported them. One person said, "I'm safe enough with them." Relatives of other people using the service felt the service provided was safe and they were confident their family members were being cared for safely. A relative stated, "[Name] is safe, staff are good at helping her to the commode safely. Nobody treats her badly."

Care staff knew and understood their responsibilities to keep people safe and protect them from harm. Care staff told us what actions they would take if they had concerns for the safety of people who used the service. Records showed staff had undertaken training to support their knowledge and understanding of how to keep people safe. However, the provider was not clear about their responsibilities in reporting safeguarding issues to us. They were unsure of which relevant agencies they needed to notify and as a consequence they had not notified us about some safeguarding concerns. It was noted however that appropriate referrals had been made to the Local Authority safeguarding team. The provider told us in the future when a referral is made to the local authority safeguarding team they will send the appropriate notification to the CQC.

We looked at the provider's procedure to identify and manage risks associated with people's care. Staff told us risk assessments contained sufficient instructions for them to follow to minimise the risk of harm to people. For example a member of staff told us if a person required two care staff to undertake their care call, they would not support the person until the second care worker arrived. Potential risks to people's safety, health and welfare had been assessed. However, moving and handling risk assessments we looked at had not been fully completed. For example, the moving and handling risk assessment for one person contained no information about the areas in which the person required assistance or the equipment which was used to support them. This did not ensure people were supported in a consistent manner to minimise risk. People's home environment had been risk assessed to ensure the care and support people required was provided within an environment that was safe for people and staff.

Care staff we spoke with were consistent in their responses about what actions they would take in the event of an accident or incident, such as finding a person on the floor. This demonstrated staff understood what action to take in an emergency to keep people safe.

Overall, people told us that they thought there were enough staff to meet their needs, however on occasions care was not provided at the agreed times or in a consistent way. . For example, some people told us different care staff turned up to those listed on the rotas which were sent to them and they had to wait as the care staff were sometimes late. One person said, "They send a rota and then sometimes come at different times." A relative told us, "We get many different carers, often a bit late and it's a bit upsetting because they clash with meal times." Another relative felt some care staff did not understand the implications on their family member's medical condition when they were late or delayed. The relative said, "I have complained about care staff coming late, we get meals at the wrong time." This demonstrated people's care was not being consistently delivered in accordance with their care plan and did not ensure their safety.

Care staff we spoke with told us staffing levels were currently sufficient to allocate all the calls people required. However, one member of staff told us, "Some office staff do not reallocate calls straight away even when care staff have given them plenty of notice that they will not be able to cover a particular call. Sometimes it's left to the last minute to look for cover." Another member of staff stated, "I think there are enough staff." Another member of staff said, "At the moment there are enough staff, however sometimes in a middle of a shift the office may contact you to do an extra call." We spoke with the office coordinator about staffing levels, they told us there were three vacancies which had been recruited into and that the new staff were going through the relevant employment checks.

Several relatives told us care staff administered medication safely. A relative said, "They [staff] use the medication administration records, they're on the case with that." We looked at how staff supported people to take their medicines. Care staff told us they had undertaken medicine training and records confirmed this. We looked at a sample of medication administration records and found these had been completed correctly without any signature gaps or omissions. However, care plans did not contain guidance to support care staff in administering medicines safely They did not specify the level of support people required to take their medicines. They also contained no information regarding the application of prescribed creams so care workers knew where the creams needed to be applied. This meant that the provider was unable to assure themselves that people received their medicines safely. We discussed this with the provider who told us action would be taken to address this by including this information on care plans.

We looked at three staff recruitment files, to check that safe recruitment procedures were in operation, to ensure people were cared for by staff of good character. We found the provider had carried out Disclosure and Barring Service (DBS) checks. The DBS is a national agency that keeps records of criminal convictions. However, we found the provider was not undertaking thorough recruitment checks to ensure staff were safe to work with the people who used the service. For example one staff member's file contained a reference, but it was not clear who had completed the reference. We did not see any evidence to confirm the reference had been checked for authenticity. On the second recruitment file information regarding the staff member's previous employment history was not clear. The office coordinator assured us they would share this information with the provider so that actions could be taken.

Requires Improvement

Is the service effective?

Our findings

Most people we spoke with said the staff met their needs. One person said, "Most of the carers are good." Another person told us, "Most of the care staff are good; they know what they are doing. I feel they are well trained to carry out their duties." A relative said, "The care staff are reasonably well trained and are professional." However a couple of people felt the care staff did not all have the skills or knowledge to provide care and support. Some relatives we spoke with told us some care staff were more experienced than others. Comments included, "We get a different level of performance depending on who comes" and, "At first we had really good carers, then they changed and they were not as experienced."

The office co-ordinator told us that new care staff were required to complete 'shadow shifts', before they were assessed as being competent before working alone in the community. This involved working alongside more experienced care workers. Care staff were also required to complete training in the form of learning booklets as well as a practical session in moving and handling. The provider told us staff competency was checked through observations during spot checks. Care staff we spoke with confirmed that during the induction period they completed shadow shifts. One member of staff said, "Shadowing experienced staff was very good, you pick up on a range of skills." Care staff told us they received training they needed to care for people effectively. One member of staff said, "The training is really interesting, we also receive regular updates in training." We saw a sample of records which showed staff had completed training in a range of courses relevant to their role.

The office co-ordinator told us formal supervision (a meeting with a manager to discuss any issues and receive feedback on a member of staff's performance) with care staff took place annually. Care staff told us they received supervision, although the frequency of this varied between individual staff. For example one member of staff told us they received supervision every month, whilst another said they had not had supervision for some time. Care staff told us they felt supported by their immediate line managers. One member of staff said "[Name] is approachable and always helpful."

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. The provider did not have effective arrangements in place to ensure staff knew what to do when people were unable to give valid consent. Information regarding people's capacity to consent in different areas of daily living had not been assessed. For example in one person's care records information stated "[Name] has memory problems." We saw no capacity assessment, confirming when the person required support to make decisions. We were unable to see how the provider determined whether a person lacked capacity. The office coordinator told us that they were currently working on a new assessment form which will include a section on mental capacity

Care staff told us they had undertaken training on the MCA. However, care staff we spoke with did not have a clear understanding of how to ensure a person consented to the support they received if they lacked capacity.

Care plans in place did not show what help and support people needed to prepare and eat meals or any food preferences they had. One person's care plan at lunch time stated their meal should be the "Correct consistency." We discussed this with the office staff who confirmed that all meal preparation for this person was carried out by their family and the staff assisted the person to eat the meal. This was no clear from reading the person's care plan. Care staff told us if they had concerns about people's food or fluid intake, they would raise them with the office staff. They told us that the office staff would discuss these concerns with relatives or health and social care professionals. Care staff said that if there were concerns about a person's dietary intake they sat with people whilst they ate their meals to ensure they had eaten and had some fluids. All the care staff told us that they ensured they left drinks for people in between calls.

People's care records contained information on their medical conditions. Care staff we spoke with told us that they would seek medical support if they were concerned about a person's health care needs or report the concerns to the office staff. One member of staff said "If the person needed immediate medical support I would contact the ambulance service and if the person was unwell I would report this to the office who would contact the GP." This demonstrated that staff monitored people's health needs to ensure that appropriate medical intervention could be sought as needed.

Good

Is the service caring?

Our findings

People using the service and relatives we spoke with said the staff were kind and caring. People we spoke with told us they felt comfortable with the care staff that supported them. One person said, "Most of the care staff are good. They are kind and very caring, I've no complaints." Another person told us, "The staff are very kind and helpful; they go out of their way to help." A relative stated, "They [care staff] are all very caring people, we have never had anybody impatient."

People told us care staff supported them to maintain their dignity and privacy. Relatives felt their family members were treated with respect. Comments included, "There is a lovely regular carer, who treat's [Name] with respect" and "Care staff treat [Name] with respect and maintain his dignity. I am not concerned about their [care staff] manner with [Name]."

Care staff we spoke with had a good understanding of people's needs and were able to tell us how they cared for people in a dignified way. They were able to describe how they would respect people's privacy and dignity when providing personal care to people. Care staff told us they ensured doors were closed when people were using the bathroom. A member of staff told us, "I always make sure curtains are drawn when supporting a person." Care staff we spoke with understood the importance of promoting people's independence and enabling them to maintain or develop activities of daily living such as washing their face. One member of staff we spoke with said, "I support people to do something for themselves such as washing their hands or putting a tea bag in a mug, when making them tea." This demonstrated that staff treated people in a dignified manner, respecting their privacy and dignity.

Some people we spoke with were unable to recall whether or not they were involved in planning their care or whether staff had gone through their care plan with them when they started to use the service. Relatives we spoke with confirmed they were involved in the planning of their family member's care. One relative told us, "We set up a care plan at the start." Another relative said, "There is a care plan, which the care staff are familiar with." Care plans we looked at had been developed with the involvement of people using the service or their representative. We saw that people or their representative had signed to denote their agreement in the care records we looked at. Entries in a communication book we looked at in the office were written in a respectful manner.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in July 2014, we found there was a breach in meeting the legal requirements relating to person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans were not kept up to date where people's needs had significantly changed and staff did not have access to information that was specific to the individual.

At this inspection visit we saw there had been some improvements and care plans had been kept up to date. Care staff told us they received sufficient information regarding people's individual care needs and how to support them. One member of staff told us, "The care plans and risk assessments contain enough information regarding a person's needs." Another member of staff said "Care plans are kept at people's homes, which usually contain sufficient information on the person's needs." However care plans we looked at lacked detail regarding people's needs and did not include information on people's preferences. For example, one care plan stated, "Carers to assist with all meals" but there was no explanation as to how staff should do this. For another person the care plan recorded "[Name] requires verbal prompting with personal care," but did not explain what this entailed or how the person preferred the assistance to be given.

The office coordinator told us that the office manager, as well as another member of staff visited people and their relatives as part of the initial assessment process. This was to ensure the provider had a clear understanding regarding the person's expectations of the support they needed so the person could be confident that the service was right for them. Assessments of people's care and support needs were undertaken and used to develop people's care plans. The office coordinator showed us a revised assessment form template they were working on to ensure information regarding people was personalised and contained key information such as people's preferences, likes and dislikes.

The office coordinator told us that care plans were updated annually or when a person's need had changed. They told us this was through a meeting with the person using the service and their relatives/representatives where appropriate. Relatives we spoke with confirmed reviews had taken place. However one relative said "The care plan was reviewed at some time, possibly two years ago."

People and relatives told us they felt the provider was responsive. They told us the office staff were quick to respond, for example if they had a preference for individual care workers. . One person said, "There was one carer I could not warm to, which is important for the care I get. The agency were very responsive to changing the care staff."

Some people told us they received inconsistent support from the agency as they were supported by different care staff. For example one person told us, "I do try to speak to them [Office staff] about having too many different staff, it can be off putting to get different ones all the time." Another person said, "You get used to care staff and then they are changed." People told us they preferred to have the same care staff. This demonstrated there was a lack of continuity in the care people received.

People and relatives we spoke with were aware of the provider's complaints process. A relative said, "If there are any issues they are sorted out quickly." However, other people had mixed views as to whether their concerns would be listened to or acted upon. One person said, "I can complain and I have about staff coming late. I have spoken with the office staff, I'm not sure it made much difference." Another person told us, "The carers often come and say they have had an extra visit added to their schedule. I have spoken to them about coming later, but it's made no difference." This demonstrated complaints raised were not always resolved in a satisfactory manner.

We looked at the provider's systems for managing complaints, including their complaints procedure. We saw the procedure was accessible to people as it was included in the information pack kept at the person's home. However, the procedure did not contain details of the Local Government Ombudsman where the complainant could escalate their complaint if they were dissatisfied with the outcome of their complaint by the provider. The office staff informed us the complaints book had been misplaced, so we were unable to see if complaints received by the provider had been addressed and resolved.

Care staff we spoke with knew how to respond to complaints if they arose. They all told us if anyone raised a concern with them, they would tell the person how to make a complaint and would share this with the office staff or the on call person.

Requires Improvement

Is the service well-led?

Our findings

Some people and relatives we spoke with told us communication and administration issues with the office staff were not good. A person said, "The office is not very efficient they don't pass messages on." A relative told us, "There's a lack of communication between carers and the office staff." Another relative stated, "I can cancel the lunch time call but the message doesn't always get passed on." Some care staff we spoke with felt that the communication with the office staff was not always effective. A member of staff told us, "The office doesn't always let you know if a person has been admitted to hospital. It's not until you arrive at the call and ring the office and you find out the person is in hospital." Another member of staff said, "Tweaks are needed to improve the service. There is lack of communication between office staff, care staff and people who receive care. For instance if I am running late I will ring the office, but they don't ring the person to let them know." Another member of staff stated, "I sometimes feel supported, it depends on who you speak to in the office. Some office staff are more supportive, they will look into an issue. However other office staff don't follow things up." This showed that systems were inconsistent to ensure effective communication between people using the service, staff and management and not responding in a way people would have expected.

There was an out of hours call system; this was confirmed by people using the service and staff. A relative said, "If I have not had the rota I have to ring the out of hour's telephone number, as I don't know who's coming at what time." We received mixed responses from care staff regarding the out of hours call system. Care staff told us that depending on the member of staff providing on call support, not all staff got back to them in a timely manner. One member of staff said, "You can ring half a dozen times and get no response, which can make you feel you are on your own. However when other staff are on call they ring you back straight away."

The registered manager was not based at the office and we were told that they visited the office at least twice a month. The day to day management of the service was delegated to the office manager. Care staff told us she was supportive and approachable. Care staff told us that they were aware of the registered manager. However two care staff told us that they had not met the registered manager. One member of staff told us, "I have never met the registered manager. The office manager is the main point of call, and she is supportive."

Care staff told us staff meetings were not held regularly. One member of staff said, "We have not had a staff meeting since October 2015. Another member of staff told us, "Staff meetings do not take place regularly." The office coordinator told us attendance by staff was variable. They stated the provider was looking at ways of ensuring staff meetings were accessible to the staff group. There were no minutes of the staff meetings available. Staff meetings are an opportunity to reflect on working practices, share information and identify areas where the service needed to improve. However care staff told us newsletters were produced by the office staff which covered administrative issues, any updates on people receiving care and information on working practices.

The provider did not always effectively deploy care staff to meet people's needs. Some care staff told us the

rotas did not always contain sufficient travel time between care calls. One member of staff told us, "The rotas don't take into consideration the traffic during peak times." Another member of staff said, "There is sometimes not enough travel time as the office have overlapped the calls. For example you may have a call from 9.00am to 9.45am, but the next call on the rota starts at 9.30am." Another member of care staff stated, "The rotas need to be rearranged so that carers are in one area rather than crossing areas." Care staff said that poor scheduling had impacted on calls running late. However, one member of care staff told us that they always stayed for the allocated call time, to ensure people received the care they required.

The provider did not have organised systems in place for storing and retrieving information. The office coordinator told us that annual satisfaction surveys were given to people and their relatives to complete, to establish their views on the running of the service. The office coordinator told us that they were unable to recall if surveys were sent out during 2015. We were shown a blank satisfaction questionnaire template, which included questions on the quality of the care provided and privacy and dignity.

The provider was not able to assure themselves people received their care in accordance with their care plans. Checks on whether care staff arrived on time and stayed for the agreed length of time were not undertaken. The provider had not identified that care plans did not provide specific guidance for staff about how to provide care to meet people's needs in the way they required and preferred.

There was no evidence to show that learning from incidents took place and appropriate changes were put in place to minimise risks to people using the service and others. For example the provider did not complete a review of all accidents and incidents in the service, to identify any patterns or issues that could be addressed to avoid recurrence.

The provider was not clear about their CQC registration requirements in relation to submitting notifications about any changes, events or incidents that they must inform CQC about.

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

Spot checks on staff were undertaken to make sure they were meeting people's needs. A relative said, "The manager comes and checks everything is going okay." Spot checks included observing care staff whilst they carried out moving and handling tasks and supporting people with medicines. Communication logs and medication administration records (MAR) were audited. For example the office coordinator told us MAR's were checked to ensure there were no gaps or errors. The office coordinator told us where issues had been identified, for example, a missing signature on a MARs, action would be taken to address the error. We looked at a sample of MAR's which had been completed correctly.

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 leadership and management of the service and its governance systems were not robust, which impacted on the quality and consistency of care being provided and restricted the development of the service. The provider did not have a system to ensure themselves that the service they were providing was governed well and that they were meeting their obligations. Regulation17(1) (2) (a)(b)(c)(e)