Home Is Where the Help Is Ltd

Home is where the help is

Inspection report

Office G08
Ashington Workspace, Lintonville Parkway
Ashington
NE63 9JZ

Tel: 01670719941

Date of inspection visit:
29 January 2019
30 January 2019
01 February 2019
04 February 2019

Date of publication:
05 March 2019

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

We carried out an unannounced comprehensive inspection of Home is Where The Help Is Ltd on 29 January 2019, 01 February 2019 and 04 February 2019. This was the first inspection of the service since it was registered in August 2018. We received concerns in relation to staff recruitment and training. As a result, we undertook the unannounced comprehensive inspection of the service to look into those concerns.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, 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 take action 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. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 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."

At this inspection we identified a number of concerns and shortfalls resulting in a breach of regulation 7 (requirements relating to registered managers), regulation 9 (person-centred care), regulation 11 (need for consent), regulation 12 (safe care and treatment), regulation 13 (safeguarding service users from abuse and improper treatment), regulation 17 (good governance), regulation 18 (staffing) and regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found a breach of regulation 18 (notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

These breaches were because the registered manager did not effectively manage the regulated activity, the provider did not have oversight of service, staff were not safely recruited, safeguarding incidents were not escalated to the local Safeguarding Adults team, staff did not receive appropriate training or induction, the provider had not appropriately assessed the risks to the health and safety of people using the service, medicines were not safely managed, consent was not sought before supporting people, there was no

governance framework in place and the Commission was not notified of a safeguarding incident which effected a service user.

Home Is Where The Help Is Ltd is a domiciliary care agency. It provides personal care and support to people living in their own homes. It provides a service to a range of people including those living with a dementia and physical disabilities. At the time of inspection there were 27 people using the service and the service was unable to inform us how many people were receiving the regulated activity of personal care.

There was a registered manager in post who has been registered with the Care Quality Commission (CQC) to provide regulated activities since August 2018. A registered manager is a person who has registered with the CQC 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. The registered manager and provider were not meeting all of the requirements or regulations and had not submitted notifications to the Commission.

During the inspection we found that there was no governance framework in place to assess, monitor and improve the quality and safety of the service. Accidents and incidents were not recorded. There was an infection control policy in place but staff had not received training around this. Staffing levels reflected the needs of people using the service and visits were appropriately scheduled to meet people's needs. This meant the service did not have enough suitable staff available to support people, as the service did not safely recruit staff or provide training. Records did not show that people had consented to the delivery of care. People did not have comprehensive care plans or initial assessments in place in their care records.

Risks people faced had not been identified, assessed or mitigated. The service was not using suitable staff to support people with care in their homes. Staff had not received training around safeguarding vulnerable adults as part of their induction or on-going training. Staff were not safely recruited and had not been provided with induction training required for them to safely support people. There were policies in place designed to help keep people safe from abuse, these included the provider's safeguarding vulnerable adults' policy and information for people and relatives about reporting abuse. People told us they felt safe with the care provided by staff from the service.

Medicines were not safely managed; best practice guidance was not being followed by staff and staff had not received training around medicines. People did not have medicine care plans in place with all of the necessary information needed to fully support people. Care plans for 'as required' medicines were not completed and not recorded on people's medicine administration records. Records regarding other professionals involved in people's care were missing from people's care records.

There were no records to show the service was actively requesting feedback from people to help assess and improve the quality of care delivery. People told us that staff treated them with kindness, dignity and respect whilst delivering personal care. People were supported to maintain social relationships through enabling sessions with staff. There was an equalities and diversity policy in place at the service but staff had not received training around this.

There was no complaints procedure in place but people and their relatives were provided with information on how to raise a complaint when joining the service. The were no complaints received or records available to demonstrate this. People and their relatives told us that they felt confident in raising a complaint and who they would contact. No one was accessing an advocacy service and people we spoke to were unaware of this type of support available if they needed it.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Assessments had not been made for people for safety reasons in line with the Mental Capacity Act 2005. Staff did not receive training around the MCA.

You can see the action we have asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff were not safely recruited and there were not enough suitably trained staff to safely support people.

Medicines were not safely managed. Care plans did not include details around medicines or protocols for 'as required' medication. Medication records were not accurately completed.

Staff did not receive training around safeguarding procedures. There was a safeguarding policy in place at the service. Safeguarding incidents were not escalated to the local Safeguarding Adults team.

Is the service effective?

Inadequate

The service was not effective.

Consent to care was not sought before staff provided care to people.

Staff had not received training before supporting people with personal care.

People did not receive care in-line with best practice guidance.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives told us they were involved in care planning but this was not always recorded.

People were positive about the caring nature of staff.

People told us staff upheld their privacy and dignity.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs had not been fully assessed. People did not receive person-centred care which was regularly reviewed and updated.

People were not supported with end of life care and staff had not received training around this.

The service did not have a robust complaints procedure in place but people knew how to raise a concern.

Is the service well-led?

Inadequate

The service was not well-led.

There was a registered manager in post. The registered manager did not understand their role or responsibilities.

There was no governance framework in place to assess, monitor and improve the quality and safety of care provided to people.

Statutory notifications were not submitted to the Commission.

The registered manager had a clear vision for the service but was not delivering in line with this.

Home is where the help is

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 undertaken 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 was prompted in part due to a number of incidents and intelligence we had received from partnership agencies regarding the safety of people, the safe recruitment of staff and staff not receiving training before providing support to people in their homes. The team inspected the service against all five questions we ask about the services: is the service safe? is the service effective? is the service caring? is the service responsive? and is the service well-led?

This inspection site visit took place on 29 January 2019 and was unannounced. Inspection site visit activity started on 29 January 2019 and ended on 04 February 2019. It included reviewing documentation and speaking to staff, people and relatives via telephone interviews. We visited the office location on 29 January 2019 and 30 January 2019 to review care records and policies and procedures.

The inspection was carried out by two inspectors.

As the provider had only been registered with the Commission for less than 12 months they had not completed a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed the information that we held about the service. This included any statutory notifications received. Statutory notifications are specific pieces of information about events that happen within the service, which the provider is required to send to us by law.

We sought feedback from the local authority and safeguarding adults' teams, and reviewed the information they provided. We also contacted Healthwatch, who are the independent consumer champion for people

who use health and social care services. We used the feedback gathered from these parties to inform our inspection and judgements.

During the inspection, we spoke with five people who used the service, three relatives and two members of staff including the registered manager and the quality and assurance manager for the service. We reviewed the care records for three people receiving the related activity and the recruitment records for six members of staff. We reviewed policies, procedures, audits and records relating to how the service is ran.

Inadequate

Is the service safe?

Our findings

Staff recruitment was not safe. We reviewed the staff recruitment files for six members of staff and found that only three members of staff had a current Disclosure and Barring Service (DBS) check in place. The DBS check a list of people who are barred or have restrictions in place from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role. This meant that people who were receiving personal care were at risk as staff may have not been suitable to provide care to them.

We were informed by the Quality and Assurance manager that one person was acting as a carer and visiting people in their homes, was accompanied by the registered manager at all times. This person was not employed by the service and did not deliver any aspect of personal care. We reviewed the care records for one person who used the service and found that this carer was signing for medication and delivering personal care to people without being employed by the service. The registered manager confirmed that this member of staff was delivering personal care unsupervised to people and did not have a recruitment file.

Two members of staff had disclosed to the provider that they had a conviction or were under police investigation. The registered manager had not risk assessed the suitability of these two members of staff before they were allowed to support people without supervision. The registered manager confirmed that only they and two members of staff had a valid DBS check in place and staff without these checks would be removed from carrying out care to people.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Fit and proper persons employed.

There was no medication policy in place at the service. Staff had not received training in the administration of medicines or had their competencies checked before supporting people with their medication. There were no protocols in place to administer 'as required' medicines. These protocols are used by staff to provide guidance on when 'as required' medicines should be administered and of how often people required additional medicines such as pain relief. One person informed us that staff administered their 'as required' pain relief but this was not recorded in the care file, daily notes or medical administration record (MAR). This placed people at risk of serious harm as there was no accurate record of how much medicine the person had taken. Medication administration records (MARs) were not correctly completed in line with NICE guidelines and there were no medication care plans in place for the care files we reviewed. Care records did not show that any reviews had taken place or that audits of medication administration records had been carried out.

During the inspection we found that accurate, completed and robust risk assessments were not in place for people who used the service. People's care records stated that people were at risk, for example of falls, COPD related issues, chest infections and circulatory problems. There were no corresponding risk assessments to assist staff to provide safe care to people. Environmental risk assessments for people, for example oxygen storage, had also not been completed. There was an infection control policy in place at the service but staff had not received training around infection control and the importance of following

procedures.

We raised these issues with the registered manager who confirmed staff had not received training around medication and that staff had been administrating medicines to people. The registered manager told us they would provide training to staff for safe administration of medicines in the next week. The registered manager also confirmed that they would review people's care records to make sure records were accurate and in-line with best practice guidance.

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

Staff had not received safeguarding training as part of their induction or on-going training. This meant that people were at serious risk of abuse and improper treatment as staff did not have training about safeguarding vulnerable adults. The registered manager confirmed that staff had not received this as part of the induction process and that they would arrange training in the next week for staff.

We reviewed the minutes of a meeting between the registered manager, deputy manager and a member of staff regarding an allegation of financial abuse. The registered manager had discussed the incident with the staff member but had not escalated this to the local Safeguarding Adults team . They had not fully investigated the concern or shared outcomes with people, staff and relatives. This showed that staff and the registered manager were not aware of their responsibility around safeguarding vulnerable adults. The registered manager informed us they would revisit the incident and escalate appropriately.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

We reviewed the accidents and incidents log at the service and found there was no information present. The registered manager told us accidents and incidents were to be analysed for trends and themes but at the time of inspection this aspect of the governance framework was not present.

People and their relatives told us that they felt safe with the care provided by staff. A person told us, "I feel safe with the care provided." One relative told us, "I feel very safe with the care my parents receive."

People told us that staff were generally on time for visits and stayed for the designated amount of time. The service did not use any agency staff and had calculated the number of staff needed to support people at the correct times. People and their relatives told us that they received personal care from regular staff members. One relative told us, "We've had no missed visits and a couple of late visits due to an incident at a previous person's visit. But they always get in touch to tell you when someone will arrive."

Inadequate

Is the service effective?

Our findings

People in receipt of care from the service did not have their support assessed and delivered in line with current best practice standards and guidance, such as the National Institute for Clinical Excellence (NICE) guidance. For one person's care record we reviewed medicine administration records (MARs) medicines had not been correctly inputted with a second signature to confirm the correct medicine and dosage was correct. We reviewed archived MARs and found this had not been completed on these either. NICE guidance was not followed for accurate record keeping as not all administrations of medication were recorded.

People's care records did not contain initial assessments or completed assessments. This meant that people may not have had their needs fully assessed by the service, and by skilled staff, before receiving support with their care. One person's initial assessment we reviewed was only partially completed and sections were left blank.

Where people were at risk there were no risk assessments present. One person, who was having their foods and fluids recorded, did not have a care plan for nutritional needs or a risk assessment present. This meant that people were a risk of not maintaining a balanced and healthy diet.

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

Staff had not received any training as part of their induction at the service, this included training in safeguarding vulnerable adults, infection control, first aid, medication and moving and handling. New staff who did not have any previous qualifications associated with Health and Social Care had not received an induction in line with the 'Care Certificate'. The Care Certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by staff to provide safe, effective and compassionate care. Staff without training and competency checks had been supporting people with care. The registered manager confirmed that staff had not received training as part of their induction and they would arrange this for them. They confirmed that all staff would be fully trained by March 2019. There was no supervision policy in place and 6 members of staff had not received regular supervision sessions to support them in their role.

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

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 checked whether the service was working within the principles of the MCA. We found there were no

mental capacity assessments or best interest decisions completed for people's care and treatment, for example for medication and life changing choices about serious medical treatment or where to live. Records of best interest decisions were not present in care files and there was no record of involvement from people's relatives, GPs and staff. One person had an emergency health care plan (EHCP) in place which was noted on their care information sheet but we could not find any details around this or what steps should be followed by staff.

For the three care files we reviewed there were no signed consent to care records. The registered manager told us that in some instances people had verbally consented to care but this was not recorded.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent.

People's care records did not show any documented involvement from other health and social care professionals. One person's care information sheet had contact details for a partnership agency who were also providing support. There was no involvement present in the care record. This meant that staff were not working effectively with various agencies to make sure people accessed other services in cases of emergency or when people's needs had changed. One relative told us about an instance where a staff member had contacted the GP and them about a change in the presentation of a person receiving support. This demonstrated inconsistent levels of care delivered by the service. Care plans were not detailed and did not reflect any advice and guidance provided by external health and social care professionals.

Daily communication notes were kept for each person detailing the support provided on each home visit. These contained a summary of the care and support delivered and any changes to people's preferences or needs observed by staff. This helped ensure staff had the latest information on how people wanted and needed to be supported. These were easily accessible to staff to allow for a consistent approach to care at each visit.

Requires Improvement

Is the service caring?

Our findings

When people first joined the service, an initial assessment was completed. We found that not all initial assessments had been completed for people. This assessment contained details of social relationships, activities people liked to do, religious needs and their personal care needs. People had a personal profile in their care records which also covered family, jobs, a brief history of their life, interests and relationships. Out of the three care files we reviewed we found that only one person had a fully completed assessment. Care files also included personal preferences, for example how they liked to be bathed and preferred products to use for personal care.

People and their relatives told us that staff from the service were caring and kind. One person told us, "Staff are absolutely lovely." Another person said, "I couldn't be happier." Relative's comments included, "Perfectly happy with the care", "[Person] is really improving thanks to the staff", "They (the staff) are amazing ."

Whilst we heard about staff being caring when they engaged with people living in their own homes, we found deficits in the service which showed the provider was not ensuring the service was caring overall. The caring nature of the staff was undermined by the lack of staff training and rigorous oversight of the service delivery. We found people's well-being was compromised by the standards and practices in the service.

People and their relatives told us that they had been involved in planning care. This involvement was not always recorded in care files. One person said, "I think I was involved in planning, I signed something." Relative's told us, "I was involved a little bit in care planning." Another relative commented, "I signed and updated the care plan." People's records did not reflect if choices had been given with regards to their personal care needs.

At the time of the inspection no one was accessing an advocacy service. One relative did tell us that they had received a service user guide initially and that there were some details provided within it. The pack also contained details around the service and who to contact if people or relatives had a concern.

There was an equalities and diversity policy in place at the service to help ensure that people were treated with dignity and respect regardless of their sex, sexual orientation, race, age, disability or religious belief. Staff had not received training around this but could access the policy via an on-line application. People commented that staff were respectful whilst delivering personal care and their dignity was respected.

Inadequate

Is the service responsive?

Our findings

People in receipt of care from the service did not have completed initial assessments which could be used to develop person-centred care plans. In the three care files we reviewed we found that inconsistent care was being provided. There were missing care plans, initial assessments and regular reviews of people's care records. Care plans were not regularly reviewed. One relative told us, "We've had no reviews of [person]'s care."

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

At the time of the inspection we found one person was being supported with end of life care by another external agency. The service did not have an end of life care plan in place to work in partnership with the other agency and to support the person with their wishes and needs. Staff had not received training in the delivery of end of life care. There was an end of life policy in place at the service but this was not being followed.

In the care files we reviewed, there was no evidence of reviews of people's needs with recorded involvement from people or their relatives. On relative told us, "I've been involved a little bit in care planning. They (the staff) tell me when [person]'s needs have changed." People told us that they had been asked how they would like to be supported but these conversations were not recorded in peoples care files.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person-centred care.

Care plans were developed with the information provided from the available and sometimes incomplete initial assessments. These were used to support people with their personal care needs such as personal hygiene and medication. We found that people did not have care plans in place to support them with nutrition and end of life support.

Staff carried out enabling visits with people. These visits were designed to help people maintain social relationships and attend activities. One relative told us that staff support their relative once a week by sitting and talking with them. The relative said the person enjoyed this and it also allowed the relative to attend their own activities and maintain their social circle.

When people first joined the service, they were provided with service user information, including how to make a complaint. The service did not have a complaints policy in place at the time of the inspection. There were no records available to show if a complaint or concern had been raised to the service. People and their relatives told us that they felt confident in raising a complaint and who they would contact. One relative told us, "I've got no concerns about the service. The service user guide has all the information in including complaints. We just have to contact [registered manager]."

Inadequate

Is the service well-led?

Our findings

Home Is Where The Help Is Ltd did not ensure that people had their needs met as we did not find evidence to show the regulated activity was managed appropriately. There was a registered manager in post who had been registered with the CQC since August 2018. This was in line with the requirements of the provider's registration of this service with the CQC. The registered manager was not aware of their responsibilities. The registered manager could not demonstrate appropriate knowledge of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relevant best practice and guidance or understood the consequences of failing to take appropriate action on these set requirements. The registered manager and provider did not provide sufficient evidence to demonstrate that they had full oversight of the service and the quality of care delivered to people.

This was a breach of regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Requirements relating to registered managers.

The registered manager and the provider have a legal responsibility to notify us of certain incidents. Our records showed that we had not received any notifications relating to safeguarding incidents at the service. During this inspection we found one safeguarding incident that had not been notified to the Commission. The registered manager explained to us that they were unware that this incident should have been notified to the CQC and would complete this.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

We found that the provider did not have any governance arrangements in place in relation to the monitoring of the quality of the service provision. As such legal requirements were not met and has resulted in breaches of our regulations.

We did not see evidence of partnership working between the service and the local GP, nurses and other professionals. Care files did not document information from other professionals and there were no notes to support this.

We reviewed the staff meeting file. This file did not include any minutes from staff meetings. We found there was a record confirming attendance of staff meeting in December but no record of the meeting. There were no further details of previous staff meetings or dates of future meetings present.

There were no records to show people and their relatives had been invited to provide feedback about the service. One relative told us the registered manager had contacted them via the telephone for feedback but there was no documentation to support this.

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

We discussed our concerns about the governance system not identifying the concerns we identified at our inspection with the registered manager. We were provided with some assurances in relation to the impact these issues had on the safety and quality of care that people received. For example, the registered manager removed staff from the rota who did not have current DBS checks or had received up-to-date training.

The registered manager was not present during the inspection. They provided us with requested information and assurances after the site visits had been undertaken. The registered manager was knowledgeable about the people the service supported and could tell us about each person's individual needs. People and relatives we spoke to knew who the registered manager was and how to get in contact with them. The registered manager had a clear vision for the service, but was not delivering in line with this, which they told us involved putting people at the centre of the service's focus.

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 9 HSCA RA Regulations 2014 Person-centred care People did not have their needs fully assessed, care plans were missing and were not regularly reviewed. Regulation 9(1)(2)(3)(a)(b)(c)(d)(e)(f)(I)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not demonstrate that consent was sought prior to delivering the regulated activity to people. Regulation 11(1)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding incidents were not escalated to the local Safeguarding Adults team. Staff did not receive training in safeguarding vulnerable adults. Regulation 13(1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and

proper persons employed

The service did not ensure that staff delivering the regulated activity were of good character as there were no recruitment procedures in place to assess the good character or suitability of staff employed by the service.

Regulation 19(1)(a)(2)

Regulated activity	Regulation
Personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The provider failed to ensure that service users had their needs met because the regulated activity was managed inappropriately. Regulation 7(1)(2)(b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did ensure that there were sufficient numbers of suitably qualified, competed, skilled and experienced staff deployed to safely deliver the regulated activity to people. Regulation 18(1)(2)(a)