J McKenna Ltd

Homestead Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Homestead Care is a domiciliary care service providing care for people in their own home, in Gillingham and surrounding areas. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of the inspection13 people were using the service.

People's experience of using this service and what we found
People said they felt safe and were supported by staff who knew them well. However, potential risks to people's health and wellbeing were not consistently assessed and were poorly documented. This meant people were not always safe.

There was ineffective leadership and oversight of the service. Provider quality assurance systems did not identify and rectify previously identified breaches of regulation, to ensure the quality of service provision and mitigate the risks to people.

Risk assessments and risk management plans did not describe the level of risk or how the risks were being assessed, monitored and reduced.

Medicines were not always managed safely. There were weak systems in place which failed to ensure staff administered medicines when they were due.

Recruitment checks were not always thorough to ensure people were only cared for by suitable staff.

The last rating for this service was requires improvement (published 18 December 2018), there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected
We carried out an announced comprehensive inspection of this service on 26 September 2018. Breaches of legal requirements were found we issued the provider with a warning notice . The provider completed an action plan after the last inspection to show what they would do and by when to improve the governance of the service.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for

Homestead Care on our website at www.cqc.org.uk.

Enforcement

We found two repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a further breach of regulation 19. You can see what action we took at the end of this full 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

Details are in our safe findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Homestead Care

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

The inspection team consisted of two inspectors.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection

Before the inspection we reviewed information, we held about the service and the service provider. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us 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 used all of this information to plan our inspection.

During the inspection

We spoke with two people who used the service about their experience of the care provided. We spoke with two members of staff, in addition to the registered manager and provider and newly appointed manager. We reviewed a range of records. This included four people's care records and six medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policy and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found, including looking at training data sent to us.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection we found not enough improvement had been made and rating remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection not enough improvement had been made and the provider was still in breach of regulation 12

● Risks to people were not consistently recorded or reviewed when people's needs changed, or risks increased. For example, one person fell resulting in admission to hospital. Following discharge from hospital, the person's increased falls risk was not assessed or reviewed. The provider confirmed the increased risk of the person falling had not triggered a review of the person's care needs.
●Safety concerns were not consistently identified or managed. One person was recorded as becoming verbally and physically aggressive towards staff. Neither the risk assessment or the care and support plan had any instruction for staff on how to respond to physical aggression. This meant there was a risk staff may not respond in the safest way.
● Systems were not effective in ensuring people received safe care. One person was at risk of malnutrition and dehydration. The person's care plan stated they had lost a significant amount of weight. The risk assessment identified changes in health and noted the person forgets to eat or drink. Staff confirmed the person's food and fluid intake was not being recorded. The provider confirmed this risk had not been reviewed or monitored.

Using medicines safely
● At the last inspection we found the service had poor systems in place which did not support staff to administer medicines safely. At this inspection we found concerns with medicine management remained. There were numerous gaps and crossing out on all the records. One person's record had conflicting information about their medicine administration. Their care plan stated the person needed to have their medicines after food; their medicine administration records sheets stated the person needed to have their medicine half an hour before food. The registered manager agreed the information was incorrect and needed to be reviewed.

Ongoing shortfalls in assessing, monitoring and managing risk, and medicine management were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Staffing and recruitment
● Staff recruitment procedures were not always safe. Where information gathered during the recruitment process identified a potential risk to people's safety, the provider met with the staff member to discuss this and then made a judgement about their suitability. However, these meetings were not consistently recorded, and no risk assessments were in place to address the risk the staff member might pose and how these were reduced to protect people.
●One staff member's employment history had gaps. This meant there was a risk that gaps in employment were not fully explored and unsuitable staff maybe recruited as a result.

Staff recruitment procedures were not robust. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Newly recruited staff had worked in care before, so were experienced carers. However, they had no formal induction periods. One member of staff informed us, "I shadowed for one day and was observed the following day." There was no record of their induction process and their first supervision record showed no discussion had been recorded about their suitability for the role. The provider informed us they did have blank staff induction forms but did not use them.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding policies and procedures had improved since our last inspection and staff knew the signs of abuse, and how to report concerns outside the service.
● If people were subject to a safeguarding inquiry or investigation they were offered an advocate if appropriate or required.

Preventing and controlling infection
● Staff were trained in infection prevention and control. They told us they received a good supply of Personal Protective Equipment (PPE) such as disposable gloves and aprons. Staff told us they understood their responsibilities for infection control and food hygiene.

Learning lessons when things go wrong
● There was a procedure in place for reporting and recording accidents and incidents.
● Action plans had been developed in response to safeguarding concerns and incidents. Improvements were needed to make sure actions were consistently implemented as planned.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection we found not enough improvement had been made and rating remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● At the last inspection in November 2018 this key question was rated requires improvement. We used our enforcement powers and issued a warning notice requiring improvement to governance of the service. At this inspection we found not found enough improvements had been made and the provider was still in breach of regulation 17.

● The quality assurance processes were not effective in assessing, monitoring and mitigating the risks to people. The quality assurance processes had not identified the shortfalls in care plans, risk assessments and medicine administration we found during this inspection.

● Systems were in place to monitor and evaluate the quality of the service provided. These were not effective. Medicine audits were undertaken and areas for improvement identified. However, actions taken to mitigate risks were not taken and did not identify the shortfalls we found. For example, one person had declined their prescribed afternoon medication over a period of 28 days. The registered manager told us they had not discussed this with the person or advised staff how to manage this risk.

● Where accident and incident occurred, there were no effective systems in place to review each event and identify steps to take to avoid it happening again. Although the provider told us they were confident staff would report any incidents, they were unaware of the number of incidents taking place for one person using the service.

Working in partnership with others

● The provider did not act on feedback following information shared from commissioning teams. Following a commissioning visit in December 2018, recommendations were made in regards to communication, documentation and risk management plans. At this inspection these recommendations had not been completed.

● We issued the provider with a warning notice relating to the governance of the service in November 2018. The provider had taken no specific action to comply with the warning notice. The provider told us, "We have missed working against the recommendations from commissioners, and the warning notice issued by CQC."

Quality assurance processes were ineffective and the provider had failed to act on feedback from

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

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider and registered manager knew what notifications they had to send to the CQC. These notifications inform CQC of events happening in the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The registered manager was in the process of deregistering with us. A new manager had been recruited and was in the process of registering with the Care Quality Commission.

● People told us they were happy with the support they received from staff they knew well. Staff felt well supported. Comments included, "Staffing is good at the moment we have a good team". "We are a small team, so communicate all the time."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Surveys were completed by people using the service, and people comments indicated they were happy with the service.

● Staff meetings were held, and staff felt confident their views and feedback would be listened to and acted.

Continuous learning and improving care

● It was clear from our discussions with the provider that they aimed to provide well led high quality care. However, their hands-on approach being a member of the care team had impacted on their ability to review and update care records, complete training and audit the quality of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff recruitment procedures were not robust.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely and administered appropriately to make sure people are safe. The provider did not effectively assess or manage the risks to people's health and safety.

The enforcement action we took:

placed a condition on the providers registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the quality and safety of the service provided to people were not robust enough to demonstrate good governance.

The enforcement action we took:

We imposed conditions on the providers registration