

G.R Response Healthcare Ltd

G.R Response Healthcare

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

G.R Response Healthcare Ltd is a small, family-run service located in Slough, Berkshire. It is a domiciliary care agency. It provides personal care to people living in their own houses and flats in Slough, Langley, Burnham and the surrounding areas. It provides a service to older adults; people living with dementia; people who misuse drugs and alcohol; mental health; physical disabilities and sensory impairment. At the time of our visit there were 53 people using the service.

In February 2017, and since our last inspection, the provider changed their name from Goldenrose Community Care Limited to G.R Response Healthcare Ltd. The location name also changed from Golden Rose Community Care Limited to G.R Response Healthcare Ltd.

The service had a registered manager. 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 and associated Regulations about how the service is run.

We previously inspected the service on the 28, 29 and 30 April 2015. The service received an overall rating of 'good' with 'requires improvement' in the key question, is the service effective. This was because staff who had undertaken relevant training could not confidently demonstrate their understanding of the Mental Capacity Act 2005 (MCA). We made a recommendation for the service to seek guidance on how to ensure the effectiveness of training undertaken by staff.

During this visit we found although care workers' understanding of the MCA had improved this was not the case for senior management who assessed, managed and recorded people's capacity and ability to consent. Our rating for this key question has therefore remained at "requires improvement".

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; even though there were policies and systems in place to enable them to do this.

People were not supported to express their views and be involved in making decisions. People felt staff were caring and kind. Staff had a good understanding of their care and support needs and family histories. Staff said they made sure people were treated with respect and their dignity was protected. However, some relatives felt their family members were not always treated with dignity. People were encouraged to be as independent as possible. People's confidential personal information was securely protected.

People and their relatives gave mixed feedback about staff's abilities and skills to carry out their job roles. We found the service provided appropriate support to staff to ensure people received effective care. Staff told us they made sure people's nutritional needs were met. We noted this was in line with what people said they wanted. People were supported to maintain good health.

We could not be confident people would always be protected when an alleged safeguarding incident had happened. People said they felt safe from harm but gave mixed responses about the timeliness of calls. The feedback received demonstrated further improvement was required. We have made a recommendation for the service to seek current guidance on the allocation of staff in order to make sure people receive consistency of care. Where there were identified risks in regards to people's health and welfare, risk management plans were not always in place. The management of medicines were not always safe.

People and their relatives felt the service was not always responsive to their needs. Where reviews of care were carried out, there were no records of involvement with people or their relatives. We have made a recommendation for the service to seek nationally evidence-based guidance on how to involve people and their relatives in reviews of care. People and their relatives said they knew how to raise complaints. Where the service received verbal concerns this was not handled in line with service's complaints policy. Care assessments were not always completed, therefore we were unable to determine how care assessments informed plans of care.

Where people had disabilities or sensory impairment there were no records to show how their communication needs should be met. We have made a recommendation for the service to seek current best practice and guidance on how to provide information in a format that meets people's communication needs.

There were mixed responses from people and their relatives in regards to how well-led the service was. People's care was often provided outside of planned times and had resulted in their dissatisfaction. Quality assurance systems in place were ineffective in monitoring the quality of service. There was no analysis of information gathered and the service was unable to demonstrate how they used the information to make improvements. Staff felt the service was well-led because of the support they received from management.

We found breaches of regulations as a result of this inspection. 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?

The service was not always safe.

People said they felt safe from harm but we heard mixed responses from them about the timeliness of calls.

People were not always be protected when alleged safeguarding incidents happened.

Where there were identified risks to people's health and welfare, risk management plans were always in place.

The management of medicines were not always safe.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff's understanding of the Mental Capacity Act had not improved. We found the service did not act in accordance with the requirement of the Mental Capacity Act.

People and their relatives gave mixed feedback about staff's abilities and skills to carry out their job roles.

Staff received appropriate induction, training and supervision.

Staff told us they made sure people's nutritional needs were met.

People were supported to maintain good health.

Requires Improvement ●

Is the service caring?

The service was not always caring.

People were not supported to express their views and be involved in making decisions.

People felt staff were caring and kind.

Staff had a good understanding of their care and support needs and family histories.

Requires Improvement ●

Staff said they made sure people were treated with respect and their dignity was protected. However, some relatives felt their family members were not always treated with dignity.

People were encouraged to be as independent as possible.

People's confidential personal information was securely protected.

Is the service responsive?

The service was not always responsive.

People and their relatives felt the service was not always responsive to their needs.

Where reviews of care were carried out, there were no records of involvement with people or their relatives.

People and their relatives said they knew how to raise complaints. Verbal complaints were not always handled in line with complaints policy.

Care assessments were not always completed therefore, we were unable to determine how care assessments informed plans of care.

Where people had disabilities or sensory impairment there were no records to show how their communication needs should be met.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

There were mixed responses from people and their relatives in regards to how well-led the service was.

People's care was often provided outside of planned times and had resulted in their dissatisfaction.

Quality assurance systems in place were ineffective in monitoring the quality of service. There was no analysis of information gathered and the service was unable to demonstrate how they used the information to make improvements.

Staff felt the service was well-led because of the support they received from management.

Requires Improvement ●

G.R Response Healthcare

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 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.

This inspection took place on 16, 17 and 18 October 2017. The inspection team consisted of two 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.

We did not give the provider 48 hours; notice. This was because the inspection was prompted in part by concerns raised about the service.

We asked the provider to complete a provider information return (PIR) form. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all the information we held about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it.

As part of the pre-inspection process we sent questionnaires to 42 people who received care from G.R Response Healthcare Ltd and their relatives. We received 15 responses in total. We also reviewed feedback received in the last year from two relatives of people who used the service. They had shared their experience of the service by completing the 'share your experience' form located on our website. The analysis of all the feedback received was used to inform this report.

During this inspection we spoke with seven people; nine relatives; two care workers; a supervisor; finance manager and the registered manager. We looked at five care records; four staff records; the service's policies and procedures and records relating to the management of the service.

Is the service safe?

Our findings

People and their relatives felt the service protected them from harm and abuse. Comments included, "I'm sure [name of relative] is safe with them (staff) if there is anything wrong they give us a ring", "I'm sure she's (relative) safe with most of them (staff) that come, we've had an issue with a few of them and we've made sure they don't come back", "I feel safe enough with them, they get me up in the morning and into my wheelchair and the reverse at night", "I think she (relative) is safe with them" and "I think [name of relative] is safe with them, nothing has happened to bother us."

We checked whether people were protected from abuse and neglect. We found the service had an appropriate generic safeguarding policy in place. In addition, we saw the service had access to the local authority specific procedures for reporting and managing safeguarding matters. The service reported allegations to the local authority using the correct process. Copies of the referrals were kept on file for future reference. In addition, the service sent notifications to us without delay at the time of a safeguarding allegation, as required by the applicable regulation. The registered manager showed us a log which the service used to record each safeguarding referral. This contained details such as the name of the person affected, the date of the referral to the local authority and the date of notifying us. The folder which stored safeguarding information also contained printed copies of various e-mails to and from social workers involved in the cases. The management team expressed that sometimes it was difficult to obtain updates or outcomes of cases from the local authority. We saw the service tried to find out the conclusion of referrals made, as there were records of their attempts to contact local authority staff.

Although the service reported matters to third parties appropriately, they did not keep records of checks they completed themselves when a safeguarding alert occurred. There was no evidence of checking the person's safety after an allegation arose, what fact-finding occurred, which staff managers spoke with or any associated care notes that may be required by third parties during an enquiry. We saw the service had the ability to record these details on a dedicated form or within the electronic care system used, but when we asked to see this, they were unable to show us any relevant evidence. Therefore we could not be confident people would always be protected when an alleged safeguarding incident had happened. The registered manager acknowledged this when we asked to see this evidence and was receptive of our feedback.

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

Before our inspection, we received some complaints from relatives of people who used the service regarding safe staff deployment. Feedback we received on our 'share experience form' stated people did not always know which staff member would attend, that calls were late, staff arrived despite being cancelled in advance and that there was sometimes inefficient communication from the office regarding people's visits. One relative stated, "Carers never come on time. [The] office never informs of any changes. Three times they have missed a bed time visit (of my relative)." Another relative commented, "Visits (of my relative) [were] two hours late."

People and relatives gave mixed responses about the timeliness of calls. Comments included, "It's pretty much on time really and it's the same girls who go, no one randomly turns up", "We have four calls a day (double ups), they (staff) used to be quite late but that's improved a bit after we told them. The mornings are better now but the rest of the day is still a bit off", "Yes they are on time. It's the same ladies that come", "We have had this about four months and they come four times a day and to begin with it was a nightmare, but it has improved a bit lately. For my own peace of mind I am putting in CCTV, I won't be happy till I do", "We have four calls a day (double ups) they both come together, timekeeping is a bit off, they can be more than half an hour late quite often. It's an issue on a Sunday when you're trying to cook a meal and you ring up and they say 'Well we'll get there eventually'. Some (staff) do ring to let you know but most don't, it's pretty regular carers", "We have calls four times a day (double ups). It's gone downhill lately, the morning call was at 7.30 but they don't come till 10 now, they didn't tell me why but I have to ring up about it", "We have four calls a day (double ups), they (staff) turn up together, they can be late, I don't mind, I know things can happen but what makes me cross is that they never ring and tell you."

In our pre-inspection survey, 47% of people and 20% relatives felt that care workers arrived on time. One person commented, "Call timings tend to creep (be late) and I have to complain. Call times are being logged incorrectly on paper records." One relative said, "The visits are often haphazard. The carers arrive when I have cancelled visits and have often not visited when they should."

The feedback received demonstrated further improvement was required. We discussed with the registered manager how appropriate numbers of staff were deployed to provide support to people. We found that the service had a good system in place for determining how many staff were required for each person's calls. This was based on the person's dependency and needs. For example, if a person required hoisting from a chair or bed using a sling, support calls for the person were completed by two care workers. When we asked whether a relative or friend could help with hoisting people in their home, the registered manager confirmed the service did not allow this to ensure safe moving and handling practice. In addition, where the person's care was paid for by a local authority or clinical commissioning group (CCG), the service was required to provide support calls in line with the provisions of the funding.

The registered manager told us that on some occasions, little notice was given from nearby hospitals of when a person needed to commence or re-commence their support package at home. We were told that although the service tried to accommodate short-notice requests from hospitals and others, there were times when support packages were declined to ensure enough staff were available for existing calls. In addition, where referrals for new care packages were received from some commissioners, the registered manager explained that little information was provided. This meant the service did not have the ability to determine what the person's needs or dependency was prior to visiting them. As the service became more familiar with people who received new support packages, the number of length of care visits were appropriately altered in line with their needs.

We were told staff who provided personal care worked within set geographical regions. This minimised the distance of travel between people's addresses. Staff told us that in some homes they visited they had enough time to carry out care whilst in others they did not. A staff member commented, "Some people need more time but their care package does not allow it." The management team told us that five minutes' travel time between people's calls was scheduled. We found this was an insufficient amount of time for travel between the calls, especially if the care worker experienced delays in leaving a call, or transport disruption. We found there were some inevitable times when people's calls were commenced later than the scheduled times. Reasons for late calls primarily included road works and traffic congestion at peak times, like early morning and the evening. Although the service worked with people and their relatives to have care visits planned in line with their preferences, we saw during busy periods (such as breakfast time) it was not always

possible for the service to schedule calls at the requested time. The service required some flexibility to carry out all of the calls during the peak periods, and worked with people and relatives to schedule alternate times when staff would be available.

Replacement of a person's allocated care worker or workers was sometimes required. This was mainly due to planned and unplanned staff leave. Most people and relatives spoken with told us they had same care workers who attended their homes. However, some felt they did not have sufficient notice of planned changes and that there was not enough consistency with the care workers who attended. A relative commented, "Regular carers are allocated elsewhere with new customers and are not in regular attendance...the word regular does not appear to have any meaning...we regularly keep seeing new and inexperienced carers on site, enough to upset an old and frail patient." Another person stated, "I am not at all happy about the inconsistency of regular faces (care workers)." This meant people did not always receive a service that met their individual needs.

We recommend the service seek current guidance on the allocation of staff in order to make sure people receive consistency of care.

We checked the management of people's medicines. We found this was not always safe. There were two appropriate medicines policies in place. New staff completed online training about medicines, and then were supervised during people's care calls before being independently permitted to administer medicines. Experienced staff completed online medicines training each year. Although care staff were trained in the administration of medicines, they did not have regular competency checks of their medicines management skills. This meant the service could not be assured that staff followed the correct procedures and had the necessary knowledge of medicines safety.

Some people were prompted to take their medicines and staff were required to administer medicines for others. A list of people's medicines was recorded in the service's electronic care records system. However, the medicines administration records (MARs) were not always correctly completed. We looked at four people's MARs in the computerised care system. In two people's records, we saw prescribed medicines were not given. When we looked further, the care notes did not show why the medicines were not administered. A relative gave us one explanation for this and commented, "The times are an issue, they can turn up at 6.50am which is a bit early or very late. We've had lunch calls as late as 2pm and evening calls too early. Once we had less than two hours (1hr 50 minutes) between lunch and tea and the carers had given [name of family member] [name of medicine] on both visits, so that is nearly a double dose so close together. I rang them up (office staff) and they said 'Oh we'll look into it' but I never heard anything about it." We viewed the person's computerised MAR chart and found there were no records for medicines that had been administered for the months of July, August and September 2017. We brought this to the attention of the registered manager.

Although the service identified risks to people's health and welfare, care records did not consistently show how those risks were to be managed by staff. For instance, people who had poor mobility and needed to be hoisted had been assessed at high risk of falls. Care records did not show what staff should do to minimise these risks. This meant there was the potential for people to receive unsafe care.

We looked at how the service recorded and managed accidents and incidents. Staff accidents and incidents were handwritten on a form and we saw these were filed in the service's office. The registered manager told us that accidents and incidents involving people were logged in the computerised care management system. However, no central record was kept of all incidents and accidents. When we asked, the service was not able to show any example of accidents or incidents recorded for people who received care. The service

also could not show that the management team were aware of any incidents, investigated them, mitigated the risks to the person or provide evidence they learned from incidents to prevent recurrence of harm to people.

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

Is the service effective?

Our findings

At our previous inspection on 28, 29 and 30 April 2015 we rated this key question "requires improvement." This was because staff who had undertaken relevant training could not confidently demonstrate their understanding of the Mental Capacity Act 2005 (MCA). We made a recommendation for the service to seek guidance on how to ensure the effectiveness of training undertaken by staff.

During this visit we found although care workers' understanding of the MCA had improved this was not the case for senior management who assessed, managed and recorded people's capacity and ability to consent. Our rating for this key question has therefore remained at "requires improvement".

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.

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.

There was a generic MCA policy in place at the service. This set out the requirements of the service and its staff in ensuring compliance with the legislation. We found that the service was not acting in accordance with the requirements for obtaining valid consent, the principles of the MCA and the associated codes of practice. We saw all staff were trained in the MCA principles and signage within the office was available to prompt and remind staff about their obligations. Staff training about the MCA occurred primarily via e-learning, with a quiz at the end of the module. This did not adequately prepare staff for assessing, managing and recording people's capacity and consent. We found staff sometimes misunderstood the correct requirements if consent was obtained or when best-interest decisions were required.

We found some people were capable of making decisions themselves and therefore were able to consent to care and treatment. Some people who used the service had reasons that affected their ability to provide valid consent to care and treatment. For example, some people had dementia and other illnesses that impaired their decision-making abilities. This meant that mental capacity assessments would be required to determine whether the person could legally provide any form of consent.

We found the service's computerised records had a place to record consent and people's mental capacity status. We reviewed the consent and mental capacity section of the care system and found the documentation was unsatisfactory. Although the system asked the questions and information required, staff recorded little detail in the necessary parts of the electronic form. In some people's care documentation we viewed, parts of the consent record were missing, incomplete or blank. People's signatures were not always obtained to show they had consented to their care and support package.

The records did not indicate how people or relatives were involved in the consent process and whether the opinion of any relevant healthcare professional was considered. In cases where a consent decision was necessary, and the person lacked capacity, mental capacity assessments were not completed. There was also no evidence to show that any mental capacity assessments were repeated or checked over time, in the event that someone had fluctuating ability or regained the ability to provide valid consent. The service failed to ask people and relatives for enduring or lasting power of attorney documents or Court of Protection deputyship orders. Copies of documents, where they were registered with the Office of the Public Guardian, were not kept. The service could not demonstrate that decisions were made in line with people's best interests.

We spoke with the registered manager who told us their management team had not attended the relevant training.

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

After our visit information was received about a course management were scheduled to attend. This outlined the areas to be covered and the learning outcomes. We noted there was no specified date of when the course was to begin or confirmation from the training provider that confirmed which management staff were booked to attend.

People and their relatives gave mixed feedback about staff's abilities and skills to carry out their job roles. Comments included, "They are ok the carers, some are better than others", "Trained? Well that's a thing, some (staff) are better than others and not so much the personal care things ,it's daft things like I come home and find the milk left out since the morning or it's untidy, just annoying", "They (staff) do hoist (relative) and they all know how to do that, they all seem pretty well trained", "Most of them (staff) are alright but some are not so good", "They (staff) all seem well trained", "Trained, well one lady (staff) has very good interaction with my (relative) and encourages her to do as much as she can and talks to her but another will just stand there and look and say nothing, which is not good really" and "They are very well trained."

In our pre-inspection survey, 80% of people and 60% relatives felt that care workers had the skills and knowledge to carry out their job roles.

The service provided appropriate support to staff to ensure people received effective care. Records we examined indicated that staff received appropriate training that was relevant to their roles. Training was a mixture of e-learning, external and in-house courses. Topics included moving and handling, safeguarding adults at risk, basic life support and infection prevention and control. Staff were encouraged to complete other topics like management of people with epilepsy and diabetes and how to deal with behaviours that challenge. The service's trainer kept a matrix that recorded the training staff had received, along with the date they required refresher training in each specific subject.

Staff spoke positively about their induction experience. We heard comments such as, "We had to do shadowing and I had to attend training before I could go out into the community" and "I shadowed staff and I had to attend calls with experienced staff." We found there were appropriate supervision and performance appraisals with staff. Staff participated in supervisions in the office, an annual appraisal and were also subject to 'spot' checks by the management team and supervisors. 'Spot' checks were completed by a senior staff member supervising the care worker providing support to a person in their home. All staff supervisions and appraisals completed were accurately recorded. This was supported by the staff members we spoke with. Comments included, "We have supervisions which are recorded. It's quite open and I can

raise any concerns I have" and "I get to voice my opinion which they (management) do take on board. If you have any issues they will get addressed." This showed staff received appropriate induction, training and supervision.

People and their relatives spoke about the support they received with meals. Comments included, "They (staff) all do everything they should, we leave the meals and they heat them up and get her (relative) a drink, that's fine", "They (Staff) do the meals, just microwave meals, they say they can't do anything else because of health and safety", "They give (relative) a meal at lunchtime, just what I leave out", they make my meals, just what I ask for", "Usually we do the meals but if I'm out I'd leave some soup or something and ask them to give it to (relative) but I'd come in and it would still be on the side" and "They give (relative) their lunch, I leave ready meals in the fridge for them."

Staff told us they made sure people had enough to eat. One staff commented, "I will actually cook up a meal if I have time. I will go at any lengths to ensure they (people) have a hot meal. Daily records showed the dates and times staff assisted people with their meals; what they ate and their fluid intake. We noted this was in line with what people said they wanted.

People who used the service did not always require assistance with their meals or drinks. People referred to the service were sometimes underweight and records we looked at showed staff encouraged them to eat and drink enough to maintain the best possible health. On some occasions, a food or fluid chart was used to record what a person ate or drank in a 24-hour period. This was based entirely on risk, where staff identified the person may be malnourished or dehydrated. Referrals were sometimes made by the service to GPs, dietitians or speech and language therapists when staff felt it was necessary to protect the person's health.

People were supported to maintain good health. Staff told us they interacted with community healthcare professionals to ensure people had access to appropriate assistance, as needed.

Is the service caring?

Our findings

People and their relatives were not supported to express their views and be involved in making decisions. They told us they had not seen their care plans; been invited to care review meetings and there was a lack of communication from office staff. We heard comments such as, "I've never heard from the office, no one comes here, care plan, what's that, no one has asked me anything except you" and "Care plan? Well we had one in 2014 when it started, I think someone came last year and checked it but I'm not sure, there is nothing in the house not even the care plan, not since they went electronic." We saw an inconsistency in care records of people or their relatives being involved in care decisions. This meant there was a possibility care delivered was not always centred on people's care and support needs.

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

Staff had a good understanding of people's care and support needs and personal family histories. They spoke affectionately about the people they provided care and support to. One staff member commented, "You have to bring them (people) in your conversations. I spend time with them to get to know them." However, a view of care records showed information that related to people's family histories and what was important to them was not consistently completed.

People and their relatives gave us their views on the caring nature of staff. Comments included, "Some (staff) are better with (relative) than others,(relative) can't communicate properly now but she knows who she likes", "My carer is lovely, she is very good", "They (staff) seem pleasant enough with (relative)", "Most of them (staff) are alright but some are not so good my husband gets cross with them if they want to use the toilet they should ask but they don't and they never put anything back where they found it" and "They (staff) are nice to me, there was one (staff member) who wasn't nice and I said and she didn't come back."

In our pre-inspection survey, 100% of people and 80% relatives felt that care workers were caring and kind.

Staff told us how they made sure people were treated with respect and their dignity was protected. Comments included, "I treat people the way I would like to be treated. If I am strip washing, I will cover the person's bottom half whilst I wash the top half" and "The way I speak to people (showing respect). I don't call them 'darling' but use the name they liked to be called. When I was providing personal care to a person whose family was present, I asked the family if I could put a screen up to protect the person's privacy." Minutes of staff meetings showed staff were instructed to remember when assisting people with personal care, to always ask people what they would like and not to carry out personal care in front of visitors or family members.

Relatives felt their family members were not always treated with dignity. For instance one relative told us, "I can hear my (relative whose speech was impaired) saying 'no, no, no' and I'm thinking you (staff members) should stop now but they don't." Another relative told us if they had to go out and asked care staff to assist their family member with their meal. When they arrived back they found this had not carried out." Relatives

told us they had spoken to office staff about their concerns.

In our pre-inspection survey, 93% of people and 80% relatives felt that care workers were treated with respect and dignity.

Staff told us that people were encouraged to be as independent as possible. For instance, a staff member commented, "I encourage them (people) to try first and I will assist when they need it. I assess how much they can do for themselves and encourage them when they do."

In our pre-inspection survey, 100% of people and 100% relatives felt that care workers supported them to be as independent as they can be.

People's confidential personal information was securely protected. Mobile phone technology was used to record care notes. This included call arrival and departure times, care or supported provided, and any problems or issues that the care coordinators needed to be aware of. Limited information was left stored within people's homes. When documents were no longer required in people's homes, they were archived and locked away in the service's office. Information pertaining to staff and other confidential management information was locked away or protected on computers by passwords. Only relevant staff had access to this information. Staff who provided support to people and staff based in the office did not disclose confidential information without verification or people's consent.

At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. We found the service complied with the relevant legislation.

Is the service responsive?

Our findings

Since our last visit the provider had installed a new electronic person centred care system. The person centred care system did not have the facility to allow staff to document reviews of care held with people, their family members and health professionals. People and relatives gave their views on the reviews of care that took place. Comments included, "We do have a care plan a long time ago and I think we have had a review, it's supposed to be annual but it's all online now so who knows", "Review? We haven't had one of those in years", and "We had a care plan at the beginning but not with this company, we've had so many services, re-enablement and another company before this one. I think someone came and asked us things a while ago."

In our pre-inspection survey, 79% of people and 80% relatives felt they were consulted as part of the process of making decisions about their care and support.

Where reviews of care were carried out, there were no records of involvement with people or their relatives. For instance, there were no signatures that confirmed people or their relatives' agreement with the decisions that had been made. Instead these were written from the point of view of the staff members that carried out the reviews. We asked management to provide us with written records of care reviews that showed involvement of people and their relatives. The provider did not provide us with this information during or after our visit. This meant the provider did not always make every reasonable effort to provide opportunities to involve people in making decisions about their care and support.

We recommend the service seek nationally evidence-based guidance on how to involve people and their relatives in reviews of care.

People and their relatives felt the service was not always responsive to their needs and based this upon a lack of access to their care records and a lack of response from office staff. Comments included, "I've never heard from the office", "We don't have any paperwork (care plan) in the house and that's a problem, we used to have sheets with everything on but now it is all smart phones so we don't know what they have done or at what time, we can't login we don't know how", "There is no point ringing the office, they don't want to know", "I don't ring the office there is no point", "The girls sign in electronically and when they finish they log everything on their phones, they don't write anything down that I can see, I'm told I can login and read it but my old tablet can't cope with that so I don't see what they do", "The logging in system is useless, half the time you can't login or your connection drops, it used to be written down, so that was easy to see what had happened" and "[Name of relative] needs a shower, the girls (staff) are happy to do it but they have to get the OT (occupational therapist) to come out but that was at least two months ago and I'm asking and asking and the office keep saying they are doing it."

A review of minutes of management meetings and a discussion with the registered manager showed there were no follow up visits with people to see what issues they had with the new computer based care system. This meant people did not always receive a service that was responsive to their needs.

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

People and their relatives said they knew how to raise complaints. Some people and their relatives said they had no complaints to make whilst others felt their concerns were not taken seriously by office staff, due to a lack of response after their concerns were raised. We spoke to the registered manager to find out where verbal concerns would be recorded and what action had been taken in response. We were informed office staff did not systematically make a record when a verbal concern was raised. We found this action was not in line with the service's complaints policy and procedure which stated, "A complaint can be made by telephone; in writing; by email; or in person. All responses will be made or followed up in writing." We found no written responses in relation to verbal complaints received. This meant people who raised verbal concerns could not be confident proportionate action would be taken by the provider.

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

Care assessments which looked at people's immediate and longer term needs were not always completed. Therefore we were unable to determine how care assessments informed plans of care. We noted some care records did document people's cognition; communication; physical needs; nutritional needs; social needs and medical histories.

We recommend the service seek current legislation and consider relevant nationally recognised evidence-based guidance on how to complete care assessments.

We looked at whether the service ensured people had access to information they needed in a way they could understand it and were compliant with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Where people had a disability or sensory loss, there were no specific records showing how staff should make sure information given to people was in a format they could understand.

We recommend the service to seek current best practice and guidance on how to provide information in a format that meets people with disabilities or sensory impairment communication needs.

Is the service well-led?

Our findings

The service used an electronic call management system. The computer programme provided a daily and weekly schedule of people's planned calls, and the staff allocated to attend the person's home. Staff were required to use portable devices to record their start and end times of support calls whilst at a person's house. This information could not be recorded later on or altered in the call management programme. Live monitoring of people's calls occurred throughout the day by the service's supervisors and management team. This could occur anywhere with access to a computer, including outside of the service's office. The finance manager explained and showed us how monitoring of calls occurred. Where people's calls were running late, the call management system alerted the office staff. Where possible, the service would attempt to call the person to inform them.

We looked at all calls for the period 9 October to 15 October 2017 using a report generated from the computer programme. We saw from the call management system that sometimes calls were cancelled. This was because a person was admitted to hospital or a relative was visiting a person and wanted to provide the care themselves. Appropriate records of cancelled calls were kept, and the reasons for them were logged in the call management system. We saw that some calls were recorded as shorter than planned. Staff we spoke with confirmed that this was usually at the person's request and that all care-related tasks were completed before the worker departed.

We found evidence of many calls that were late. When we asked the finance manager about this, they pointed reasonable exceptions such as a person who visited the hospital regularly and therefore the personal care visit occurred after their arrival home. This meant the person's call would nearly always be displayed as late in the call management system. Apart from this person, other calls which were recorded as late were unexplained. On some occasions, we saw the commencement of a person's care was recorded as more than an hour overdue. The service did not conduct regular reviews or analysis of the late calls; for example on a weekly or monthly basis. Without this information the service could not identify reasons, trends or themes in late calls and attempt to reduce the number of late calls or prevent on-going recurrence. This meant people's care was often provided outside of planned times and had resulted in their dissatisfaction.

Quality assurance systems in place were not effective in monitoring the quality of the service being delivered.

Regular medicines audits were not completed by senior staff. In addition, medicines incidents were not recorded in a log or register so the management team could track the number and reasons for them. There were ineffective systems in place to ensure reviews of care captured people's changing care needs.

The service relied on care staff to update them on changes that affected people. Although spot checks were carried out, there were no robust quality assurance systems in place for management to make sure the checks carried out were effective. The PIR completed by the provider in May 2017 stated the provider was updating people's care records onto the newly installed person centred care system. During our visit, we

found care records were partially or not fully completed and were inaccurate. For example, we had arranged to carry out a home visit to one person's home. The provider had arranged the visit on our behalf and gave us the person's home address. We attended the person's home at the scheduled time and got no response, after waiting outside for approximately 10 minutes, this was despite contacting the office who confirmed the person was at home. On our return back to the office, an office staff informed us they had given us the wrong address and this information had not been updated by care staff who visited the person's home every day. This meant the provider did not have systems and processes in place to identify where quality and or safety was being compromised.

The service did not review the impact the new person centred electronic system had on people and their families. We saw no documents of follow up visits carried out by staff to deal with teething problems such as, people or their relatives not being able to access the electronic care plans. Most of the relatives spoken with told us they could not and did not have the means to check the online care notes and therefore did not know what care had been delivered. This meant changes that affected people who used the service were not effectively communicated and managed.

People and their relatives told us the service actively sought their views about the quality of care and support. Comments included, "The questionnaires are a joke, it's very yes /no with no neutral or place to explain, it means nothing really", "We had a questionnaire last month", "I've had lots of questionnaires but sometimes I don't bother to fill them in", "It doesn't matter what you say it doesn't make any difference" and "We have never had a questionnaire."

In our pre-inspection survey, 50% of people and 20% relatives said the provider asked them what they thought about the service received.

As well as the provider's quality assurance questionnaire, the local authority had carried out its 'homecare services survey'. We noted the results of the survey was sent to the provider on 17 September 2017. We saw no analysis of the results and no action plan was developed to show how the service was going to drive improvements in the quality and safety of the services it provided.

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

People and their relatives gave their views on how well-led the service was. Some people felt the service was well-led however others did not feel this way and based this upon a lack of communication from office staff. Comments received included, "I'm pretty happy with it", "There is no point ringing the office they don't want to know", "If you ring they are nice", "It's ok I suppose", "The office is very helpful if you ring", "You can get through to the office alright", "The girls (staff) have too many calls it's the organisations fault. I can get through to the office, it's just that nothing alters no matter what you say", "You ring them up and it's all 'Oh we'll check' or 'We're short staffed', they (staff) don't change anything" and "Office? I didn't think they had one, we've never heard from them in ages."

Staff gave positive feedback about how the service was managed. Comments included, "Yes I do (think the service is well-led), that's why I am still working here" and "Yes it is well-managed. The relationship between staff and management is quite good." Staff said they felt listened to and were asked for suggestions on how to improve the service. A staff member commented, "Sometimes people receive single calls. I requested if we could not mix the single and double calls together. Now this no longer happens except in isolated cases." Whilst another staff member shared how management supported them. They commented, "My car broke down on one occasion and management came and drove us around to finish our calls, which I thought was

good."

We saw regular staff team meetings were held. Minutes of meetings recorded topics such as covered training; confidentiality and discussions on how to ensure the new electronic care system was used correctly. This ensured staff were aware of their responsibilities to make sure good quality assurance systems were in place.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>People were not supported to express their views and be involved in making decisions.</p> <p>There were no follow up visits with people to see what issues they had with the new computer based care system. This meant people did not always receive a service that was responsive to their needs.</p>
Personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>Management did not have a good understanding of the Mental Capacity Act. Therefore, the service was not acting in accordance with the requirements for obtaining valid consent, the principles of the MCA and the associated codes of practice.</p>
Personal care	<p>Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints</p> <p>There were no written responses in relation to verbal complaints received. This meant people who raised verbal concerns could not be confident proportionate action would be taken by the provider.</p>
Regulated activity	Regulation

Regulation 17 HSCA RA Regulations 2014 Good governance

The service did not keep records of checks they completed themselves when a safeguarding alert occurred.

The service did not conduct regular reviews or analysis of the late calls on its call management system.

There was no analysis of the results of information gathered and no action plan was developed to show how the service was going to drive improvements in the quality and safety of the services it provided.

The service did not maintain accurate, complete and up to date records in respect of people who used the service and records relating to care.

The service's quality assurance system was ineffective in identifying when quality and safety was being compromised.