At Home Support Services Limited

At Home Support Services Limited

Inspection report

Blu-Ray House, Suite 3
62 Alexandra Road
Enfield
Middlesex
EN3 7EH

Tel: 02036208833
Website: www.athomesupportsergices.com

Date of inspection visit:
02 October 2018

Date of publication:
17 December 2018

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

This inspection took place on 2 October 2018 and was announced. This was the second inspection of this service since it was registered with CQC. The first inspection took place in June 2017 and we found two breaches of legal requirements at that inspection. These were due to medicines not being managed safely and staff not being deployed effectively so they were late when going to people's homes to provide care.

At this inspection we found improvements in the management of medicines and people generally received their medicines safely as prescribed. People told us that staff continued to be late and that they sometimes did not know which care worker would arrive. People were unhappy with the staff and the way the office staff planned the staffing. Despite people's dissatisfaction and staff being late having a negative impact on people's wellbeing, the provider had improved two weeks before this inspection.They had installed a new call monitoring system so they could see where staff were and receive an alert if a care worker was running late. This gave them opportunity to inform the customer and to provide an alternative care worker if necessary. The new system was making effective improvements in the timeliness of staff attending care visits.

At Home Support Services Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults. The head office is based in Enfield and the service is provided to people living in Hertfordshire. At the time of this inspection the service was providing personal care services to 24 people. The service they received ranged between one and four visits each day to live-in care.

The service had a registered manager who was also a director of the company. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Feedback from people using the service and their relatives was that they were not satisfied with the service.They said staff were often late and they were not happy with the conduct of some staff.They said the office staff were hard to get hold of, especially at weekends.

Staff were not safely recruited as they provider had allowed staff to start work before receiving any references to check on their conduct in previous employment.

Some people using the service said that staff did not appear to know what they were doing and had not read the care plan. The provider had retrained staff shortly before the inspection and was satisfied that improvements had been made. Staff had completed training in relevant topics. The provider had recently improved staff supervision and direct observation of staff when in people's homes to see if they were working to a good standard.

People had care plans setting out their needs in a way that was easy for staff to follow. People said that some staff were caring but others were not respectful or friendly and were "rough" when providing personal care.

People told us their concerns and complaints were not always addressed fully or quickly. We saw some complaints were investigated well and the provider had given a full apology when things had gone wrong but some concerns had not been recorded properly.

The provider had recently improved their quality monitoring and was working with the local authority which commissioned their service in order to make improvements. The authority reported that they had suspended placements with this service (so no new people would be referred to the service) but that the provider was working with them to make the necessary improvements and people had begun to report improvements to their care.

We found two breaches of legal requirements which was due to staff not being recruited safely and lack of effective oversight of the service. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. The service did not follow safe recruitment processes so could not be sure staff were suitable people to provide care to older people. Staff had not been effectively deployed so people experienced late calls which had a negative impact on them. This had improved in the two weeks prior to this inspection due to the provider implementing a new monitoring system.

The provider had a good understanding of safeguarding procedures and alerted the authorities promptly if they had concerns about a person's wellbeing.

Medicines were safely managed and there were risk assessments in place to reduce risks to people's health and safety.

Is the service effective?

Requires Improvement

The service was not consistently effective. Staff received training in mandatory topics to help them in their role. There had been recent improvements in the regularity of staff supervision and observation.

People gave their consent to care and staff understood the importance of seeking consent before providing care. People received support with eating and drinking.

Is the service caring?

Requires Improvement

The service was not consistently caring. People said some staff were caring, though they said they did not have opportunity to form relationships with them as staff changed frequently. Other people thought staff were not friendly or were "rough" and didn't treat them with respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. The provider had recently made improvements in the way they managed complaints and apologised to people when they had a bad experience. People may not have experienced the improvements yet as some said that the response to complaints

was slow. Some concerns were not addressed properly.

People's care plans set out their care needs and preferences clearly and were easy for staff to follow.

Is the service well-led?

Requires Improvement

The service was not consistently well led. People using the service and their relatives expressed dissatisfaction with the way the service had been managed in the last few months.

The provider had implemented improved quality monitoring and had an action plan detailing improvements. They were working with the local authority which commissioned their service in order to improve the service.

Staff told us they felt well supported by the registered manager.

At Home Support Services Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 2 October 2018 and was announced. We gave the service 3 days' notice of the inspection site visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 2 October. It included speaking to people using the service and their relatives and talking to staff working for the service. We visited the office location to see the registered manager and office staff; and to review care records and policies and procedures.

The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience made telephone calls to people and their relatives.

Prior to the inspection we considered information that we held about this service. This included a provider information return where the provider records what they are doing to meet fundamental standards and their plans for improvement. We also considered notifications of significant events made by the registered manager, safeguarding alerts and information from the local authority who commission the service.

We spoke to five people using the service, relatives of six people who used the service, six care workers, office staff, the registered manager and another director of the company. We carried out pathway tracking where we read all the care records about a person and checked whether the agreed care was taking place. We also reviewed records. We looked at five people's care files, medicines records, complaints records,

safeguarding allegations, staff training, supervision records, eight staff recruitment records, quality assurance records, surveys completed by people using the service and management records.

Requires Improvement

Is the service safe?

Our findings

We could not confirm that all staff employed were suitable to work as care workers. This was because the provider had not complied with legal requirements when recruiting staff. Six of the eight files we checked did not have a complete employment history. The provider had not obtained evidence of their satisfactory conduct in previous jobs in health or social care. Three staff had no references at all and four had character references instead of past employers. Although the provider had noted in the files that they had requested references from previous employers, they had allowed staff to start work when they had no references for them. They also used a quality assurance officer from another company to carry out visits in people's homes without having evidence that the person had been suitably vetted. We had seen records showing staff without proper references had worked in people's homes. Two staff also told us that the provider had approached their previous employers for references after our inspection. This put people at risk of receiving a service from unsuitable staff.

This was a breach of Regulation 19 of the Health and Social are Act 2008 (Regulated Activities) Regulations 2014.

After the inspection, when we requested that staff references be sent to us, we noted that the references had been obtained after our inspection.

The service had an appropriate safeguarding procedure and the registered manager had experience of raising safeguarding alerts appropriately. Where the service had a concern about a person they alerted the authorities promptly. There had been a recent safeguarding allegation substantiated due to the service missing calls and arriving late for calls which meant people received their care late or not at all. The registered manager had learned from incidents and implemented improvements to try and prevent similar incidents. Staff had attended training and understood what safeguarding people meant.

People had risk assessments in their files, detailing risks to their health and safety and advising staff on action to take to reduce the risks.

Ten people using the service required two care workers for their care usually because they needed to use moving and handling equipment such as a hoist to get in and out of bed. We checked to see if staff working on the day of our office visit had practical training in moving people using a hoist. We found that one of the four care workers using hoists that day had not completed the training to do so. Although the staff member was booked to do this training, providing care without suitable training put people at risk of unsafe care. Another member of staff told us that they had not completed moving and handling training when they started work but had learned from shadowing other care workers. Other staff had completed this training and they told us it was informative.

People using the service told us that staff were late and didn't arrive at the agreed time. One person said that they needed two care workers to assist them to get up but sometimes only one worker came. The local authority commissioning care also informed us that there had been complaints of missed and late calls. This

had a negative impact on people. One person said they had to wait as a care worker was two hours late to come and help them eat their dinner, the food was then dry. We were told that another care worker was one hour and forty minutes late by which time the person had fallen off their chair as they needed assistance to move. Another person said that they missed an appointment as they were unable to get ready as the care worker was late. Staff generally thought there were not enough staff to cover all the work. The registered manager said they thought sufficient numbers of staff were employed.

The provider had implemented a new call monitoring system which had been implemented just before this inspection on 17 September 2018. The system monitored where care workers were and alerted the office if a care worker was running late so that they could inform the person waiting or provide an alternative care worker. This system was much improved on the provider's previous monitoring system and we could see that timeliness had improved for the two weeks before the inspection. Staff had arrived at their visits on time and office staff had been able to provide suitable cover in good time when a care worker had been delayed.

At the previous inspection in June 2017 there had been a breach of Regulation 12 due to medicines errors. Since then we had been notified of one incident where a person missed their medicines and one person told us they had been given incorrect medicine the week prior to the inspection. We reported this immediately to the registered manager who took appropriate action and no harm was caused by this error. Overall medicines management had improved since the last inspection. Medicines records were clear and staff had been trained to administer medicines.

Staff said they were provided with enough personal protective equipment (disposable aprons and gloves) to deliver care safely and minimise the risk of spreading infection. Staff were required to wear uniform and to ensure the length of their fingernails were not a risk.

The registered manager told us that they had learned from incidents where things went wrong and made improvements. The new call monitoring system was an example of learning from incidents. The registered manager said that in July 2018 there had been ten incidents where there were concerns about staff conduct, staff not reading care plans and timekeeping. They sent a letter to all staff setting out expectations and care workers signed it. Where appropriate, disciplinary action was taken against staff if they did not turn up for calls.

Requires Improvement

Is the service effective?

Our findings

Most people using the service and their relatives said they did not think the service had been effective enough due to staff having been regularly late and not always following their care plan. Each person had an assessment of their needs on file and the information in this document was used to devise a care plan.

At the time of this inspection the local authority had suspended commissioning care for people with this agency for personal care as the agency had not been providing an effective service. This was improving and if the improvements were sustained the authority planned to lift the suspension.

New staff completed a one day induction training based on the care certificate which is a nationally recognised qualification in care. They then completed a day health and safety training which included food hygiene, basic life support, health and safety, working alone and moving and handling. Some staff had not yet completed moving and handling training. The provider's training records showed other relevant training had been completed and four staff were completing level 2 or 3 health and social care diploma which was a useful qualification for this work. After training, new staff "shadowed" a more experienced care worker for one day then start to work on their own.

The service employed a quality assurance monitoring officer who visited staff when they were working to observe their practice and highlight any areas for improvement. Recently staff had been receiving more regular supervision and direct observation of their work in people's homes.

Staff had mixed views on the training provided. One said, "I have done so many training" and another said that the registered manager had "taught me a lot of things." Another care worker said that they felt one day's training before they started work was not enough to prepare them.

Most staff said they felt well supported and one said, "They listen to us whenever we communicate with them" referring to the registered manager and office staff.

People said that staff supported them with eating and drinking when this was an assessed need. Care plans gave staff guidance on what support the person needed. Staff prepared simple meals such as warming up precooked food or preparing cereal and sandwiches.

Care workers did not have responsibility for carrying out any health related activities and they alerted the office or relatives if they had concerns about a person's health.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). For people using a domiciliary care service a deprivation of liberty safeguard can be authorised by the Court of Protection. There was nobody subject to a deprivation of liberty safeguard using the service. We checked whether the service was working within the principles of the MCA. Records showed staff had completed training in the MCA and they told us they always asked people for consent before caring for them. People signed their care plan as confirmation of their consent to the contents, where they were able to do so.

Requires Improvement

Is the service caring?

Our findings

People using the service told us that some staff were kind but often rushed and they did not have a consistent team of care workers. One person said, "Some of the staff are charming, but you never know who's coming". Another said, "They're very kind, but they have too much on their plate".

People and their relatives told us that some staff were not friendly and did not treat them with respect. One person told us that care workers unplugged their electrical items to plug in and charge their own phones. This showed a lack of respect. A relative said staff talked to each other in a different language that the person did not understand whilst providing their care. Two people told us that staff were "heavy handed" or "rough." We noted that on a survey completed by people a few months previously two people had described staff in that same way. The registered manager had sent staff letters outlining the expectations for their conduct and agreed to address these concerns.

A relative told us that they had told the office staff not to send a particular care worker again as they were not caring and did not engage appropriately but the same care worker was sent to them again.

Requires Improvement

Is the service responsive?

Our findings

The service developed written care plans for people setting out their needs and wishes. The care plans were clear and easy for staff to follow when providing care to people. Staff also told us the care plans were clear.

The service had a complaints procedure. In 2018 so far, there had been 17 complaints recorded. Most complaints were about staff being late or not turning up to provide care. The number of complaints reduced after the recent introduction of the new call monitoring system. People told us they were not happy with the way their concerns had been addressed which they said was not effective or quick enough. One relative told us, "This is not the way to run a business" and another said they were in the process of changing to another agency as they felt their concerns had not been adequately addressed.

In the surveys that the provider sent to people using the service two people had mentioned that they thought staff were rough when providing their personal care. There was no record of the quality monitoring calls that the registered manager told us were made regularly. This meant we were not able to check whether concerns people raised in their survey were addressed afterwards. We advised the registered manager that each concern needed to be individually addressed.

At the time of the inspection people's feedback about timeliness of staff, communication and competence was a concern. We saw that the provider was following the required duty of candour processes. This meant that they investigated complaints and incidents and gave written apologies to the people concerned. Records showed that the registered manager was making improvements in the investigation of complaints.

At the time of this inspection the service had not provided end of life care so we did not inspect that topic at this inspection.

Requires Improvement

Is the service well-led?

Our findings

The provider had not acted quickly enough on people's concerns about the service and the competence of staff. There was no evidence that concerns in surveys completed by people using the service had been addressed individually. The provider did not have effective oversight of staff recruitment practices which led to some staff being allowed to start work without being properly vetted.

The above amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was qualified in management and nursing so had suitable qualifications for managing the service. Staff said they felt well supported by the registered manager.

The service sent out regular surveys to people using the service to find out their views. We read the surveys from February, July and September 2018. The feedback in February and July had been very poor but the recent feedback showed some improvement in the level of satisfaction people had with the service. Due to the poor feedback about the service from people using it, the local authority required the provider to produce an improvement plan which they had done. The suspension of new care packages was still in place at the time of this inspection and the service was subject to regular monitoring by the local authority which commissioned the service.

The service had made recent improvements in the monitoring of staff whereabouts to improve the timeliness of people's care calls and the supervision of staff. The service business plan included an objective to provide contracts for staff who were currently on zero hours contracts in order to provide better working conditions for their staff. The registered manager had recently improved quality monitoring processes. They had also introduced "must read" bulletins for staff informing them of concerns raised about the service and telling them what action they need to take.

The registered manager told us they were committed to making the necessary improvements to the service in order to achieve a good rating and provide a good quality service. They were working to an action plan to make improvements.

The service made the required notifications to CQC but these were at times delayed. We reminded the registered manager that notifications are required to be made without delay.

The service was a member of the Home Care Provider Association and this was a source of useful information for continued learning and improvement. They also worked alongside another agency and shared training and quality assurance work with them.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons failed to operate an effective system for monitoring risk and quality of service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons failed to ensure staff employed were fit and proper persons as they did not take out all the required checks prior to their employment.