Friendly Homecare Limited

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This comprehensive inspection took place on 7 November 2017 and was announced. We gave the registered manager three working days' notice as the location provided a service to people in their own homes and we needed to confirm the registered manager would be available when we inspected.

The last inspection took place in January 2017 and the service was rated 'requires improvement' in Safe, Effective, Well Led and overall. Caring and Responsive were rated 'good'. We found breaches of Regulations relating to safe care and treatment, fit and proper persons employed, consent and good governance. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe, Effective and Well Led to at least 'good'. During this inspection, we found that improvements had been made.

This service is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older people, younger disabled adults and children. At the time of the inspection, 13 people were using the service.

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 2008 and associated Regulations about how the service is run.

The provider had procedures in place to protect people from abuse. Care workers we spoke with knew how to respond to safeguarding concerns. People had risk assessments and management plans in place to minimise risks and incidents and accidents were recorded appropriately.

Care workers had the relevant training and supervision, including observational checks, to develop the necessary skills to support people using the service. Safe recruitment procedures were followed to ensure care workers were suitable to work with people using the service.

Medicines were administered and managed safely.

Care workers had relevant training in infection control and used protective equipment as required.

People were supported to have maximum choice and control of their lives and care workers were responsive to individual needs and preferences. People using the service had developed positive relationships with staff.

People's dietary requirements were met and care workers were aware of people's health needs.

People and their families, were involved in their care plans and making day to day decisions.

Relatives and care workers said the registered manager was accessible and responded to concerns appropriately and in a timely manner.

The service had a number of systems in place to monitor, manage and improve service delivery so a quality service was provided to people. This included a complaints system, service audits and satisfaction surveys.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Safeguarding and whistle blowing policies were up to date and staff knew how to respond to safeguarding concerns.

People had risk assessments and risk management plans to minimise the risk of harm to people and others. Incidents and accidents were recorded and managed appropriately.

Safe recruitment procedures were followed to ensure care workers were suitable to work with people using the service.

The provider had the relevant training and audits in place for the safe management of medicines.

The provider had infection control procedures in place which were followed by staff.

Is the service effective?

Good

The service was effective.

The provider acted in accordance with the requirements of the Mental Capacity Act (2005) to promote people's rights.

Care workers were supported to develop professionally through training, supervision, observational checks and yearly appraisals.

People's nutritional needs and dietary requirements were assessed and care workers knew how to support people to maintain good health.

Is the service caring?

Good

The service was caring.

Relatives of people using the service said care workers treated their relatives kindly and with respect.

Care plans identified people's cultural needs and preferences.

Care workers supported people to express their views and be involved in day to day decision making.

Is the service responsive?

Good

The service was responsive.

People and their families were involved in planning people's care. Care plans included people's preferences and guidance on how they would like their care delivered. Reviews were held at least annually.

The service had a complaints procedure and people knew how to make a complaint if they wished to.

Is the service well-led?

Good

The service was well led.

The registered manager had a good overview of the service and promoted a person centred and open culture within the service.

Care workers and families had the opportunity to provide feedback to the provider and this was used to improve service delivery.

The provider had a number of data management and audit systems in place to monitor the quality of the care provided.

Relatives of people using the service and care workers felt able to approach the registered manager and said they listened to concerns.

Friendly Homecare

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.

The inspection took place on 7 November 2017 and was announced. We gave the registered manager three working days' notice as the location provided a service to people in their own homes and we needed to confirm the registered manager would be available when we inspected. The inspection was carried out by one inspector.

Prior to the inspection we looked at the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's safeguarding team and commissioning team to gather information about their experience of the service.

During the inspection we spoke with the registered manager and operational manager. We viewed the care records of six people using the service and five care workers files that included recruitment, supervision and appraisal records. We looked at training records for all ten care workers. We also looked at medicines management for two people who used the service and records relating to the management of the service including service checks and audits.

After the inspection we spoke with three relatives as the majority of people using the service had complex needs and were not able to fully share their experiences about the service with us. We also spoke with four care workers.

Good

Is the service safe?

Our findings

At the inspection on 25 January 2017, we identified a breach of regulation relating to the safe care and treatment of people. This was because although risks were clearly identified, people's risk management plans were not always comprehensive in identifying how the risks were to be minimised. In addition, we saw secondary dispensing of medicines, which is when medicines are taken out of the original packaging and put into a different container, and there were no medicines administration records (MAR) audits. Following the inspection, the provider sent us an action plan dated April 2017, which indicated how they would address the identified breach.

During the inspection on 7 November 2017, we saw the provider had updated their risk assessments and risk management plans and improved how they administered and monitored medicines in a safe way. We viewed the risk assessments for six people. Risk assessments were completed at the time when people were first referred to the service and reviewed six monthly or sooner if required. All the risk management plans we viewed had a good level of detail about the risks, how to manage these and observations and recommendations by the assessor. We saw individual risk assessments for the use of the hoist, wheelchairs, moving and handling, finance, diabetes and mobility. Where the risk of falls was high, there was a more detailed risk management plan that included comments and observations to prevent and minimise the risk.

There was a risk assessment for the environment where care was to be provided and included both the inside and outside of the property with actions and follow up comments. We also saw a check list for equipment used to support people in their own homes, such as hoists and slings which noted the date of when the next service was due and the action needed to reduce risk. This meant individual risks were assessed and there were measures in place to minimise identified risks and to keep people as safe as possible. We saw that the risk management plans helped to protect people, and promoted independence in a safe way. For example we saw one person had a risk assessment that enabled them to go swimming.

The medicines management procedures were up to date and had separate PRN (as required medicines), non-compliance and self-administration guidelines. The provider supported two people with medicines. We saw a separate consent form to administer medicines which listed the medicine's name, dose, frequency and side effects. There was guidance on how to administer medicines, for example at what times and with meals, and how to record correctly on the Medication Administration Record (MAR). Where care workers administered people's medicines we saw they completed training and the registered manager carried out competency testing as part of their observational field supervisions. .A copy of the medicines labels and details of the pharmacy who delivered the medicines was kept on file. The service was no longer carrying out the secondary dispensing of medicines. The above meant that the provider had arrangements in place to help protect people from the risk of not receiving their medicines as prescribed.

At the inspection on 25 January 2017, we identified a breach of the regulation relating to fit and proper persons employed. This was because the provider did not always follow safe recruitment procedures. Following the inspection, the provider sent us an action plan dated April 2017, which indicated how they would address the identified breach.

During the inspection on 7 November 2017, we saw the provider had improved how they followed safe recruitment practices. The provider had systems in place to ensure care workers were suitable to work with people using the service. We viewed five employment files for care workers. The files contained a number of checks and records including applications, interview records, two references, identification documents with proof of permission to work in the UK if required, a declaration of health and criminal record checks. Where one person had a conviction on their criminal record check, we saw the provider had undertaken a comprehensive risk assessment around the disclosure and obtained additional checks to make sure the person was suitable to work with people who used the service.

Relatives we spoke with told us they believed their relatives using the service were safely supported by care workers. In the 'This is Me' profile for one person there were details on what the person required to feel safe and secure. The provider had systems in place to help protect people using the service and minimise identified risks. All the service's policies were updated in 2017 including procedures for accidents, complaints, medicines, safeguarding, whistleblowing, managing people's finance and we also saw a business continuity plan. Safeguarding adults was part of the provider's mandatory training and discussed in supervision. The registered manager completed a medicines training induction with new care workers and every year carried out medicines observations as part of the spot checks. Care workers we spoke with were able to identify the types of abuse and knew how to respond. One care worker said, "I would make a note word for word and not ask questions and pass it to [the managers]. I would go to CQC or the council if the managers took no action, but Friendly are very supportive." The provider had not raised any safeguarding alerts in the last year but were aware of their responsibility to do so with the local authority and Care Quality Commission as required.

People had incident and accident forms in their homes which were completed and sent to the office when there was an incident or accident. We saw there were three incidents in the last year which had been addressed appropriately and the registered manager undertook an analysis and recorded outcomes as part of their audit. For example for one incident we saw a record of a telephone monitoring call with the relative of the person using the service who was involved in the incident and the care worker was provided with supervision to discuss how to minimise the risk in the future.

The provider employed ten part time care workers to support people using the service. Care workers told us they felt they had the skills and knowledge to care for the people using the service. Staff we spoke with confirmed they had completed four days of training with written and practical assessments and then shadowed a more experienced member of staff. Relatives told us, "They do everything they are supposed to do" and "[The carer] comes on time and stays the right amount of time."

We saw completed rotas for seven people using the service and seven care workers which were emailed a week in advance. The registered manager told us they took the needs of the people using the service into consideration, for example they may require two people to support them, and travel time for the care workers when they were creating the rotas. The registered manager was very clear that they required a minimum of an hour to support someone with personal care, so the process was not rushed, and we saw this was reflected in the rotas. The registered manager checked people's daily notes for care worker's arrival and departure times.

The provider had reviewed their infection control procedures in 2017 and infection control was part of the staff training considered mandatory by the provider. Care workers told us they used appropriate personal protective equipment such as gloves, aprons and shoe covers and these were always in adequate supply. Infection control was one of the areas the managers observed when they completed observations of care workers in people's homes.

Good

Is the service effective?

Our findings

At the inspection on 25 January 2017, we identified a breach of regulation relating to the need for consent. This was because the provider did not record if people had the capacity to consent to their care or indicate why relatives had signed care records on behalf of people using the service. Following the inspection, the provider sent us an action plan dated April 2017, which indicated how they would address the identified breach. During the inspection on 7 November 2017, we saw the provider had improved how they recorded people's consent to care.

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.

Each person's file had an assessment and review of the person's capacity to consent to their care. There was a preliminary assessment that went on to record what individual decisions the person could make on their own, for example, eating, drinking, getting up or washing. Written comments included, '[Person] can make simple day to day decisions but needs family support with complex decision, ie finance.' In some files, where people had a learning disability, in addition to the consent to care assessment, there was a letter from a family member explaining the person's needs, how that affected their capabilities and identified what family member could sign forms, if the person could not. In other files, we saw letters from doctors explaining people's mental health needs and records documenting who the person with lasting power of attorney was.

People contributed to the planning of their care and if they did not have the capacity to do so, we saw the provider involved family members in making decisions that were in the person's best interests. Care workers we spoke with said they provided people with choice. Comments included, "Every person has the right to make his own decision and we have to be very respectful and follow their needs and give them a chance to make their own choices. We talk to people and ask them what they would like to eat, wear and where they would like to go."

Care plans indicated people should have a choice and if a person required something specific to meet their needs, it was recorded in the care plan. For example, one person's care plan noted where they liked to go out to and directed they should be able to choose where they wanted to go.
We viewed one person's care plan that said the person liked to watch videos while being supported. Another person's said they enjoyed shopping and noted they liked routine so will buy the same things. One care plan described the triggers for certain behaviours for one person, how this might manifest itself in the person's actions and guidance for care workers on how to manage the person's response. Another person's care plan noted they needed time to do the activity they preferred rather than going straight into the care plan task which they were not very engaged in. There was guidance for how to respond if the person did not engage.

Relatives thought care workers were skilled at providing support and told us, "They are caring and professional", "They're very kind and supportive" and "They look after [person]. The carer knows what they are doing." Care workers told us they read people's care plans so they knew how to provide appropriate care and support. One care worker said, "When we come into [the person's home] there is a folder with everything – medicines, risk assessments and care plans. It describes what the client does and doesn't like. It's very important to look at the care plan and see what they need and to follow the procedures. I always do an ongoing risk assessment when I go in."

Care worker's inductions included a signed off checklist that instructed what part of the induction needed to be completed each day and a shadowing record. Care workers had the required skills and knowledge to meet the needs of the people using the service. We saw evidence of probation records, regular supervisions, appraisals and unannounced field supervisions which included observations on a number of competencies such as moving and handling, personal care, communication and medicines administration. One care worker told us, "[The registered manager] comes by surprise to see what I am doing. It's very helpful to me. He tells you, this has to be done like this." In addition, the provider had reviews of people's care every six months and undertook telephone monitoring every three months to get feedback from people or their relatives on how care was being delivered.

We saw an up to date training data base for care workers. Medicines competency testing included a workbook completed annually with an observational mock up and the provider had training equipment in the office so care workers could complete moving and handling training which included a practical assessment.

Where care workers provided support to people to eat their meals, there were guidelines in the care plan and risk assessments. The care plan recorded the person's appetite, ability to make their own meals and snacks, preferred mealtimes, places to eat, favourite foods, dislikes, special diets, food allergies, foods forbidden by culture or religion, cut / pureed food, assistance required and equipment needed and noted if a person had diabetes and required less sweets. Care plans provided information on hydration and we saw a risk assessment for nutrition covered a number of key areas and recorded the action to take to minimise the risk, the outcome and the follow up. One person's care plan had an email from the provider to the person's advocate who ordered their meals explaining what the person did and did not like not eat.

Care plans provided appropriate information to meet people's day-to-day health needs. All the people the provider supported, except one person, lived with their families and they would be the primary contact for healthcare matters and referred people to health professionals when required. However, care workers told us if they saw any changes in a person, they would inform the family so the appropriate decisions could be made about the health of the person.

Good

Is the service caring?

Our findings

People we spoke with said the care workers had developed caring relationships with people using the service. Comments included, "[The service] is very good. [Person] has the same carer", "They are always respectful but also have a sense of humour", "They are quite sensitive to [person's] needs", "They always treat [person] with dignity" and "[Care worker] comes in the morning and is happy and jolly."

The registered manager said the times of calls and the care worker's suitability were discussed during reviews. The registered manager had regular contact with the people and their families as it was a small service. There was a continuity of care workers, so care workers came to know the person and their needs and could recognise changes in a person. One care worker told us they encouraged people with their interests and got to know their background. "One client sings all the time, so I sing with her. One client likes to read so I encourage her to read and to go to the library. I learn about their background and I'm non-judgemental. If they have pictures or artefacts around the house, I ask about them."

Each person's file had a 'This is Me' profile which provided information on the person's family background, what they like to be called, where they lived and medical conditions. Care workers we spoke with were able to tell us about people's individual preferences and needs. They also included them in the decision making process and promoted independence. Comments included, "I ask my client what they would like to eat for breakfast, lunch and dinner. If we go out, I ask where they would like to go and what they would like to do, and my job is to enable them in a safe way" and "Give [person] the shopping basket so they can choose what they want and give them the money to pay." We also saw information around how to communicate with people who were nonverbal. For example one person used facial expressions and hand and finger movements. The guidelines directed staff to be observant of these physical indicators and to help the person communicate by ensuring they were wearing clean glasses and used their communication book.

The provider supported several people who had learning disabilities and although we saw the care plans had information around communication, we noted that the care plans were not in an easy read format. We discussed this with the registered manager, who agreed to improve the care plans for people who required a more person centred format for their particular needs.

The registered manager told us, "When we carry out personal care we encourage people to carry on doing the things they can do and promoting independence is in the care plan. People can choose either a male or female carer" and "The service provides a minimum of one hour for personal care so care workers did not have to rush and has time to talk to people, especially those they did not see regularly. That's' the reason there are no half hour calls." Care workers said, "With personal care you need to be very respectful and make sure you cover the client with a towel or blanket. I always act as professional as I can" and "It is important I am not hurting the person. Ask if he feels okay. Encourage people to do things like take a shower. Don't force them, try to be nice so it is their decision not ours." The care plans accommodated people's preferences. For example one person preferred to watch videos rather than participate in personal care. To accommodate this, the service had extra time built in, so they were not rushed and the care worker could engage with the person.

The service did not provide end of life care but care plans included information around what religion people were, if they were practicing and the arrangements to be observed in the event of their death.

Good

Is the service responsive?

Our findings

People using the service and their families were involved in planning their care to meet their needs. The provider met with people in their homes to complete an initial assessment that encompassed all aspects of the person including their background, culture, capacity to consent to their care, individual preferences and the environment. Each person had a comprehensive baseline assessment that covered all areas of their needs for daily living and this formed the basis of the care plan. The registered manager told us they tried to match care workers with people using the service and said, "The service user is first and foremost so plans are based around them." Care workers were introduced to the person and shadowed a more experienced member of staff before they began working with the person to get to know them.

Care plans were person centred and we saw instructions in people's care records for those who could not mobilise independently on how they would like to be positioned and how to achieve this. Details around how to support people with dressing and using the hoist for one person included, 'Please use effective communication with me throughout the task. I will let you know if I am in pain through expressions or sounds, so good observation is required.' The communication section of the care plan included what language people used, if they required any aides, if they used Makaton, signs, pictorial information and their preferred mode of contact, for example, letter, phone or email. We saw that even when medicines were administered by the family, the care plan listed the medicines and people's allergies so care workers were aware. Care plans were signed by the person using the service or their family if appropriate and the registered manager who was also the assessor.

We saw evidence that people using the service were involved in their reviews. The provider had a separate care plan review form they completed and used to update the care plan. The reviews covered the various areas of support and had a comments and actions section. It was signed by the person or the appropriate relative and the registered manager. Relatives told us, "We have a copy of the care plan", "Reviews are done regularly" and "We have reviewed the care plan." A care worker told us, "We have a three month review. It's about them [people using the service]. So they are involved. Prompt but don't answer for them."

The provider had a complaints procedure updated in 2017 that included a policy statement and a complaint investigation form with findings and proposed response. People using the service were given a service user pack with a complaints procedure and the registered manager told us, "We encourage people to ring." Relatives told us, "There is guidance in the service user pack. I've never had to complain" and "[Registered manager] is responsive. He's good. When we had a problem with carers, he sorted it out." We saw the provider received a number of compliments including a professional who wrote, 'She does seem a lot happier with your help and support' and 'Thank you so much for sending us [care worker]. She is absolutely perfect for us.'

All the people using the service were privately funded and lived with their families, which meant the provider did not have much contact with other professionals. However there was continual and on going liaison with people using the service and their families so there was a good line of communication.

Good

Is the service well-led?

Our findings

At the inspection on 25 January 2017, we identified a breach of regulation relating to good governance. This was because the provider did not always record outcomes or analyse service information such as incidents and accidents, nor did they have audits for care records, care workers' files, medicines or finance. Following the inspection, the provider sent us an action plan dated April 2017, which indicated how they would address the identified breach.

During the inspection on 7 November 2017, we saw the service had improved their data management systems to support the delivery of a more consistent quality of care. The provider had systems in place to monitor the quality of the service. Audits were documented with outcomes and actions where improvements were needed. We saw evidence that medicines administration records, finance records and incidents and accidents were audited monthly. There was a checklist at the beginning of each person's file and the electronic system provided requested reports. For example we saw reports indicating when field and office supervisions and appraisals were due for care workers and when service user's reviews were due. As it was a small service, the two managers maintained the data bases and undertook supervisions, appraisals and reviews which provided them with an overview that contributed to them managing and monitoring the service more effectively.

The service had a registered manager and an operations manager. The managers both covered shifts, which gave them an opportunity to meet with people and their families to develop relationships. Relatives told us, "The management are excellent. If I need to go out they find the same person to cover", "I can't fault the management. They are a small agency. They are friendly but entirely professional" and "I think it [agency] is excellent in every way."

The registered manager spoke regularly with people and met them in the community when they covered calls, attended reviews or were doing care worker observations in people's homes. Feedback about people's care was also received through telephone monitoring which asked if care workers completed their duties satisfactorily. Most feedback was very positive but one person's feedback recorded an incident they were not satisfied about. Action was taken that included the care worker receiving supervision about the issue. We spoke with the relative who provided the feedback and they confirmed the incident had been satisfactorily resolved.

Care workers said they had worked with the managers on numerous occasions and comments included, "Really lovely people to work with. They're the sort of people you can go to. They take your concerns on board and they have [a] whistle blowing [procedure]", "Very open relationship. I can relay my concerns to [registered manager].They are very accommodating" and "They listen to our needs. When we have concerns, they resolve it – always." The registered manager said, "We have an open culture and everybody is comfortable talking to each other. It is very personal because it is so small."

There were transparent processes for staff to account for their decisions and performance and the registered manager provided constructive feedback through observations, supervisions and annual

appraisals. The managers and care workers kept in touch through emails and regular phone calls. The service had a team meeting in May 2017 and another was scheduled for November 2017. We also saw a survey to care workers and people using the service had been sent out last year and was due to go out again in November 2017 to gather feedback on how service delivery was provided.

The registered manager had completed a train the trainer course and the operations manager had enrolled on a leadership management course. The provider also planned to do more training with the local authority. The managers kept their knowledge up to date by attending provider forums with the local authority and by subscribing to relevant organisations that provided them with updates. The registered manager was also aware of their responsibility for notifying CQC about significant events affecting people using the service.