Action for Children

Action for Children Herts Domiciliary Care

Inspection report

3 The Boulevard
Ascot Road
Watford
Hertfordshire
WD18 8AG

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15 February 2019
19 February 2019

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03 April 2019

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

About the service: Action for Children Herts Domiciliary Care is a domiciliary (home care) care agency. It gives personal care to children and young adults living in their own houses and flats. There was one young adult receiving the regulated activity at the time of the inspection.

People's experience of using this service:
We could not speak with the person using the service or their parents to ask for feedback on the service they received. This meant that we had to base our judgement on what the manager and staff told us as well as the information we reviewed when we visited the service's office. Following our visit to the office we had a meeting with the provider and the manager of the service to discuss the provider`s plans to develop the service.

The person who received support in their own home regularly used another respite service owned by the provider. Staff working in the respite service supported the person twice a week with personal care in their own home.

A specific care plan was not developed for the care the person received in their own home. The care plan from the respite service had been used to provide the care. Staff told us they knew how to support the person safely because they were supporting them for a long time.

Risk assessments were developed to assess health risk and risk when using equipment, however these were not specific to the support the person received in their own home.

Staff told us they received training relevant to their roles, however this did not always include training relevant to staff who supported adults.

The provider had no effective governance systems in place for this service as only one person was using this service at the time of inspection. However, they sent us their action plan to evidence how they were planning to develop the service and implement robust governance systems.

Rating at last inspection: Good. (Last report published on 20 May 2016).

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Follow up: We will continue to monitor intelligence we receive about the service to ensure the next inspection is scheduled accordingly.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Action for Children Herts Domiciliary Care

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 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.

Inspection team:
The inspection was carried out by one inspector and an inspection manager.

Service and service type:
Action for Children Herts Domiciliary is a domiciliary (home care) care agency. It provides personal care to people living in their own houses and flats. Action for Children Herts Domiciliary provides care and support to children and younger adults.

The service had a manager who was not registered with the Care Quality Commission. The the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was announced. We gave the service 48 hours' notice of the inspection site visit because we needed to make sure that the manager would be available.

We visited the office location and spoke with the manager on 15 February 2019. On 19 February 2019 we had a meeting with the manager and the provider`s representative to discuss their plans for developing the service and give feedback on initial findings of the inspection.

What we did:

Before the inspection we reviewed information, we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We received feedback from the local authority and reviewed the commissioner's report of their most recent inspection.

We requested the provider information return (PIR) to be submitted to us in August 2018. This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make. However, this information had not been sent to us.

Following the inspection, we spoke with two staff members.

We looked at a care plan for the person who received support and reviewed other records relating to the management of the service like policies and procedures, staff`s training and recruitment records.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Systems and processes to safeguard people from the risk of abuse.

- Staff told us they received safeguarding children training. They told us they would report any concerns to their manager and they were aware of local safeguarding authorities they could report to externally.
- Staff told us they had not received and were not knowledgeable about the differences between safeguarding children and safeguarding adults' procedures. The provider`s policy covered both procedures, however because the people using their services were mainly under 18 staff were not sufficiently up to date with the current legislation and guidance.
- Staff told us they reported to their manager any concerns they had. For example, in February 2018 staff reported to the previous registered manager unexplained bruising on a person`s body. However, although the registered manager at that time spoke with the person`s family they could not establish how the bruising occurred but still did not report to local safeguarding authority.
- The provider sent us an action plan following the inspection where they were planning to complete safeguarding adults training with staff by the end of March 2019.

Assessing risk, safety monitoring and management.

- At the time of the inspection the risk assessments in place for people staff supported in their own home were relevant for the provider`s respite service.
- Risk assessments to consider a person`s own home environment and any risks involved when staff were supporting a person in their own home were not in place.
- Staff were able to tell us what risks were involved and how they mitigated the risks for people when they used equipment necessary and carried out personal care at home.
- Following the inspection, the provider sent us a sample of risk assessments they carried out following the inspection in people`s own home to ensure safety of both person and staff.

Staffing and recruitment.

- There were no staff employed specifically for Action for Children Herts Domiciliary care service. The staff employed by the provider to work in their respite service provided the support for people in their own home.
- Staff underwent employment checks prior to their appointment to ensure they were of good character to provide care.

Using medicines safely.

- Medicine administration was not required at the time of this inspection from staff when they supported the person in their own home. However, staff told us and records confirmed they had training and were knowledgeable in safe administration of people`s medicines should people require support..

Preventing and controlling infection.

●Staff told us they had training and were using personal protective equipment when providing personal care to people.

Learning lessons when things go wrong

●The manager showed us staff meeting minutes held at the provider`s respite service where they discussed the care at home service with staff so that any lessons could be shared.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations have been met.

Staff support: induction, training, skills and experience.

●Staff told us they received training to understand people`s health conditions as well as in areas like autism, epilepsy, infection control and others. However, we saw that refresher training in safeguarding had not done yearly and only one staff member had received training in understanding the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

●Staff told us they felt supported to carry out their roles by the manager and they had regular meetings and supervisions to discuss their training needs.

Staff working with other agencies to provide consistent, effective, timely care.

●Staff worked together with staff employed by a different care service when they supported a person in their own home. Staff told us they worked well together and the care was led by the staff from the other service in the person`s own home because they were more familiar with the person`s needs in the home environment.

Ensuring consent to care and treatment in line with law and guidance.

● The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

● We checked whether the service was working within the principles of the MCA.

● There was no mental capacity assessments carried out by the manager and they as well as staff were not confident in how they had to apply the Mental Capacity Act principles in their daily work with people. The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

●Staff told us that relatives were involved and took decisions in regard to the care the person they supported received. Staff told us they got to know the person well and they could establish from their facial expression that they were consenting to the care they received. Following the inspection the manager told us they sourced more training for staff and started assessing people`s capacity.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.

●Following the inspection, the manager carried out assessments and put care plans in place for people using this service.

●Staff were using care plans in place from the provider`s respite service when supporting people in their own home and these were not relevant for the support people received.

Supporting people to eat and drink enough to maintain a balanced diet.

●Staff were not required to offer support with the nutritional needs of the people in the service at the time of this inspection.

Supporting people to live healthier lives, access healthcare services and support.

●Staff were not required to offer support to people at present to access any health care services. This was done by the person`s relative.

●Staff told us they raised any concerns they had about people`s` health with their family members.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may not have been met.
Supporting people to express their views and be involved in making decisions about their care.
●Staff told us they relied on people`s facial expressions when providing personal care to ensure people were comfortable and agreed with the support they received.
●Care plans were not developed to show what means of communication were tried to involve people in their care and ensure their voice was heard.
●There were no clear systems and processes in place for staff to know how to support people who transitioned to adulthood to take decisions about their care.

Ensuring people are well treated and supported; respecting equality and diversity.
●People were supported by staff who spoke about them with kindness and respect.
●Staff knew people`s likes, dislikes and preferences and they told us how they included people in conversations even when people were not able to communicate verbally.

Respecting and promoting people's privacy, dignity and independence
●Staff told us they protected people`s dignity and privacy when they provided personal care.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were met by staff; care plans were not developed for the support people received. Regulations may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
●Staff knew people well and they could describe in detail how people needed and liked to be supported. However, the care plans in place had not been developed for the support people received in their own homes
● The manager ensured that only staff who knew people well were allocated to support people in their own home. This meant that people were supported in their own home by the same staff who provided care to them in the respite service they used regularly.
●The care plans developed for the respite service described people`s likes, dislikes and preferences and staff told us they used this information when they delivered support in people`s own home.

Improving care quality in response to complaints or concerns
● The provider`s had a complaints procedure and the manager told us they shared this with people and relatives to ensure they knew how to raise their concerns.

End of life care and support
●The service was not providing end of life support to people at the time of the inspection.

Requires Improvement

Is the service well-led?

Our findings

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may not have been met.

At this inspection we found the quality assurance processes used by the manager and the provider were ineffective and did not pick up on the issues identified at inspection. These included lack of care plans and risk assessments for the service provided in people`s home, lack of mental capacity assessments, and lack of training for staff in safeguarding adults procedure. We found the provider in breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The manager took over the management of the service from the previous registered manager who left in November 2018. They manager told us they were planning to register with CQC shortly.
- The manager was enthusiastic to provide a good quality service to people and they told us they had identified some of the issues we found in this inspection. However, they needed more support from the provider to develop their knowledge and understanding about their management role and responsibilities.
- The provider detailed in the action plan they sent us following the inspection how they planned to support the manager to develop the necessary skills to manage the service effectively. They told us they planned training and support from another manager from a similar service.

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

- Staff told us they always checked with people and family members if they were happy with the support they received.

Continuous learning and improving care. Working in partnership with others.

- Following the inspection, we received assurances from the provider that they had sourced additional training for staff to understand how to deliver care and support to people in transition to adulthood in line with current legislation.
- The manager told us they had liaised with people`s social workers to ensure that mental capacity assessments were to be carried out where needed.
- The manager worked in partnership with the local authority to plan for increasing the number of people using the service.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.

- Staff told us they did their best to ensure people could rely on them for personalised care and support.

They told us they never rushed people and took their time to ensure people remained calm and relaxed whilst receiving personal care.

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 At this inspection we found the quality assurance processes used by the manager and the provider were ineffective and did not pick up on the issues identified at inspection. These included lack of care plans and risk assessments for the service provided in people`s home, lack of mental capacity assessments, and lack of training for staff in safeguarding adults procedure.