Dwell Limited

Long Lea Home Support

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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection was announced and took place on 16 and 19 October 2015.

Long Lea Home Support is a medium sized independent domiciliary care agency that provides personal care and support to people in their own homes in North Warwickshire. People who receive a service include those living with physical frailty due to older age and / or health conditions including Parkinson's disease and dementia. At the time of the inspection the agency was providing a service to 121 people. Visits to people ranged from quarter of an hour up to a 24 hour service. The frequency of visits ranged from several visits each day to a weekly visit depending on people's individual needs.

The agency is required to have a registered manager in post. 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

Summary of findings

the requirements in the Health and Social Care Act and associated Regulations about how the service is run. At the time of the inspection the agency had a registered manager in post.

Care was not always planned to take into account and minimise risks to people. Individual risk assessments had not been completed. Staff were not always aware of actions to take to reduce the risk of injury to people. Pre-employment checks to ensure staff were of good character did not always take place before staff worked with people.

People told us they received support with their prescribed medicines, however, medicine records needed to be improved. Care records did not contain information about people's medicines. Staff record when they had given people their medicines, but not what medicine they had given.

Mixed feedback was received about how effective the service was. Most people and their relatives felt care staff who knew them had the knowledge and skills needed to support them. However, some people and their relatives felt new staff or staff covering their visits did not always have the knowledge and skills they needed to meet their needs. Staff understood the basic principles of the Mental Capacity Act 2005. Staff were supported through meetings and an out of office hours on call system.

Staff were described as kind and caring by people they supported. People felt respected and their independence was promoted by staff.

Care was not always responsive to people's needs. Care records lacked information so when visits were covered by either new or different staff, they did not have the information they needed. People and their relatives knew how to make a complaint if needed but those who had raised a concern or complaint did not always feel it was responded to well.

There were systems in place to monitor the quality of service provided to people. This was through feedback from people who used the services, their relatives and audits. Audit procedures did not always identify areas where improvements needed to be made. People did not always experience a consistency in the care workers that undertook their calls. Call visits did not always take place within the time slots people had agreed to.

Summary of findings

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 consistently safe.

Risk assessments to protect people from risks associated with their care were not always in place, so staff did not always have the information they needed to safeguard people from harm. The provider had a recruitment policy in place but had not always completed the planned pre-employment checks to make sure staff were of good character before they worked with people. People received their medicines as prescribed, but medicine records did not record what staff had administered to people.

Requires improvement

Is the service effective?
The service was not consistently effective.

People were supported by staff who received training to help them undertake their work, but people did not always feel staff had the knowledge and skills they needed. Records of team meetings did not consistently give staff clear guidance about how to improve their practice. Staff supported people's choices and accessing healthcare services.

Requires improvement

Is the service caring?
The service was caring.

People and their relatives told us they thought staff were kind and caring. People were treated with dignity and respect and staff encouraged people to maintain their independence whenever possible. People had privacy when they wanted it and their personal information was kept confidential.

Good

Is the service responsive?
The service was not consistently responsive.

People and their relatives were involved in planning how they wished to be supported. Although people's care needs were assessed, staff did not always have the information they needed. Care records did not reflect people's individual needs and were not detailed in describing how tasks should be undertaken. People and their relatives knew how to make a complaint if needed, but did not always feel they were responded to well.

Requires improvement

Is the service well-led?
The service was not consistently well led.

There was a clear management structure to support staff and they felt supported by this. Although there were procedures in place to monitor the

Requires improvement

Summary of findings

quality of the service, these had not always identified where actions were needed to make improvement. Audits did not always identify where areas needed to improve. Recording and investigating processes into accidents and complaints were not always followed.

Long Lea Home Support

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 16 and 19 October 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be available to spend time with us. The inspection team consisted of two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). 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 received the PIR and used the information to plan our inspection.

We reviewed the information we held about the service. This included information shared with us by the local authority and notifications received from the provider about, for example, safeguarding alerts. A notification is information about important events which the provider is required to send us by law. In March 2015, we received anonymous concerns about staff conduct which we shared with the local authority. The provider took the action they needed to investigate the concerns. In September 2015, we received an anonymous concern about confidentiality which we discussed with the deputy manager as part of this inspection.

We undertook a survey prior to our inspection to give people the opportunity to give us their views about the service. We posted 50 surveys to randomly selected people that used the service. We received a return rate of 48% which consisted of 24 surveys completed by people that used the service and 4 completed by people's relatives.

We spoke with ten people and / or their relatives about their experiences of using the service. We spoke with seven care workers, one senior care worker, the care co-ordinator, the field care supervisor, the finance manager, the operations manager and the registered manager of the agency. We spent time with and observing office-based staff and their handling of the operational call monitoring system. We reviewed a range of records, which included care records for seven people and three people's medicine administration records. We reviewed seven staff induction, training, support and employment records, quality assurance audits, minutes of staff team meetings and people's feedback that had been sought by the provider about the quality of service provided.

Requires improvement

Is the service safe?

Our findings

The provider protected people against the risk of abuse. Staff told us they had completed safeguarding training and said they knew how to raise concerns. One staff member said, "If I thought someone was being abused, I would phone the office straight away." Another staff member said, "If my concerns were not followed up, then I would contact the local authority or you at CQC." This showed us staff were aware of their responsibilities in protecting people from the risk of abuse.

One hundred per cent of the people who responded to our survey told us they strongly agreed they felt safe with staff supporting them. People we spoke with said they felt safe with the care staff in their homes and carrying out the agreed tasks. One person said, "I feel perfectly safe with the carers." However, twenty five per cent of relatives who responded to our survey strongly disagreed their relative was safe with staff.

Care was not always planned to take into account and minimise risk. One relative told us, "My family member fell. I feel that staff did not know how to keep them safe when using the equipment." We found the person had no falls risk assessment in place. Their care record did not provide staff with information about the equipment used to transfer the person from their bed, or how to position them to reduce the risk of a fall. Although the deputy manager had been made aware of the person's fall whilst supported by staff, no review of their care or risk assessment had been put into place. We discussed this with the registered manager and they said, "I'll get onto that right away."

We looked at seven people's care records to see how risks were assessed and managed. Generic assessments such as environmental home risk assessment, which recorded health and safety information about people's homes, had been completed. However, we found individual risk assessments, where needed, were not completed. Of the seven care records looked at we expected to see individual risk assessments in place for five people which described actions care staff should take to reduce the risk of injury to those people. This would enable staff to refer to the information if needed. One person's initial assessment described them as 'prone to falling' but there was no falls risk assessment. Another person's care record noted 'mobility is not very good at times' but gave no further information to staff about how to reduce the risk of injury. A further care record said 'balance can be poor, often gets worse as the day goes on' but we found no risk assessment or information to tell staff how to reduce the risk of injury.

Although staff were able to tell us how they kept people safe from the risk of injury whilst undertaking agreed care tasks for people they supported on a regular basis, they did not have the information to refer to if needed. One staff member told us, "I'd look around to make sure the environment was safe. For example, that nothing was on the floor that the person might trip over." Another staff member said, "If I've got to know the person then I know how to keep them safe." We asked staff if they had the information they needed if they covered visits or had new visits to people. They said that although they read people's care records in their house, they felt they could be more detailed about how to keep people safe when tasks were carried out.

Some staff we spoke with knew how to check people's skin to make sure it was not getting sore. One staff member said, "I check people's skin for any redness. Any concerns I would record it and report it to the office. The office would phone the community nurse." One care record looked at was for a person at risk of skin breakdown. We saw hospital information in their care record describe them as 'at medium risk of pressures areas.' However, there was no risk assessment or information in the agency's care plan about pressure area management. We discussed this with the senior carer and they said, "The information should be there really. But, if staff have concerns we tell them to phone the office. We'll then contact the community nurse to tell them about our concerns. Any call will be noted on the electronic log."

Staff spoken with told us they had an interview before they were employed. They said they provided previous employment details so the provider could complete pre-employment checks to make sure they were of good character. We found not all of the provider's planned checks had been completed in three of the seven staff employment files looked at. We found one staff file had no disclosure and barring certificate or record of one having been completed. The Disclosure and Barring Service (DBS) makes checks to see if a person has a criminal record. We saw the person's reference did not give the provider any information because 'no comment' had been entered. A further two staff files showed us staff had commenced

Requires improvement

Is the service safe?

working with people, and although their references had been requested, they had not been returned to the provider. We found no risk assessments to show the provider had given consideration to this before staff commenced visits to people. We discussed these issues with the registered manager and they said, "I would have expected a risk assessment to have been completed by the deputy manager or to have waited for references before they started working." The registered manager took immediate action to apply for the DBS for one staff member and obtain references for three staff members.

We spoke with the registered manager about the number of staff employed and scheduled visits to people. They told us that had recently recruited more care staff and felt they employed sufficient staff to meet people's needs. People's support needs were assessed to determine whether they required one or two care staff. People said they had the right amount of staff turn up for their visits. However, one relative told us, "My family member requires support from two carers each visit but they do not always turn up at the same time." Another relative said, "When my family member's carer left the agency we were left for some weeks without any carer."

Some people were supported by staff to take their medicines. One person said, "Staff help me with my pills and give me a glass of water." Staff told us they had completed training to administer peoples' medicines safely which included checks on their competence. We looked at three people's medicine administration records (MAR). Although staff had signed to record they had given people their medicines, there was no record on the MAR of what medicine they had supported the person to take. We discussed this with the senior carer and they said, "Medicines are in pharmacy blister packs so we don't list the details on the MAR or in the care plan." We found that staff administered from pharmacy blister packs and other packaged medicines that did not always have a pharmacy instruction label on. This meant staff did not always know what the medicine was or what the GP had instructed about taking the medicine. We discussed the safe management of medicines with the senior carer and they said, "I'll add the medicine information onto people's care records so staff have the information to refer to."

Requires improvement

Is the service effective?

Our findings

We received mixed feedback from people and their relatives in our survey when we asked them if staff had the care skills they needed to support them. Eighty-eight per cent of the people who responded to our survey told us they strongly agreed staff had the right skills and knowledge. Fifty per cent of relatives strongly agreed with this. People and their relatives we spoke with also gave a mixed response. One relative told us, "We feel staff have the skills they need for the job, they are brilliant." However, one relative told us, "Staff training seems to be one size fits all, regardless of the level of care required." Another relative said, "Not all the carers have the skills they need." This meant that whilst most people felt staff had the skills needed for their role, some did not and this may have been linked to the level of care and support needed by some people.

We spoke with staff who had started working for the agency this year and found they had different induction and training experiences. One staff member said, "I did shadowing shifts, but did not complete any other training before working with people. I'd done care work before so felt I knew what I was doing." Another staff member said, "I completed shadowing shifts and training before working alone." A further staff member said, "My training lasted about three hours and after a couple of shadowing shifts, I worked alone." The finance manager said, "Some staff may experience a different induction based upon their needs and previous experience." A few relatives told us they did not feel new staff had the knowledge or skills they needed. One relative said, "The carer told me they'd never had any dementia care training but my family member had dementia and the carer didn't understand their care needs." The registered manager told us new staff completed the care certificate over a twelve week period from the start of their employment which would provide or build on their skills. However, we found there was no system in place to assess knowledge and care skills of new staff to determine what training they needed, or to refresh on, before working with people. Staff employed for over a year described training as 'spot on'.

Most staff told us they had supervision meetings with a senior carer and unannounced 'observation checks' on their practice. Staff said they had team meetings to keep them updated. The senior carer said, "Team meetings are used to communicate important things to staff, such as how to improve practices." One relative told us, "I buy gloves for the staff because they don't have any with them." However, we saw stocks of gloves were available for staff at the office and staff we spoke with said they were aware of the importance of using them. We saw that issues raised by people such as staff not always wearing gloves or aprons had been addressed with staff in the August 2015 team meeting. The senior carer told us if care staff could not attend team meetings they could read the minutes at the office. We found the meeting minutes confusing because the operations manager had stated personal protective equipment (PPE) should be worn, but the minutes also recorded them telling staff they would 'prefer care staff to use PPE unless they are 100% happy there is no risk involved'. This showed that although issues raised by people were addressed, staff were not given clear guidance on best practice to minimise the risk of cross infection.

Sixty-four per cent of the people who responded to our survey told us they strongly agreed managers and staff understood their responsibilities under the Mental Capacity Act (MCA) 2005. None of the care staff or senior carer we spoke with could recall having completed training on the MCA. Although we saw training records did not list MCA, the registered manager told us it was delivered within the dementia awareness training. Most staff had an understanding of the principles of the MCA. One staff member said, "If I thought a person was making poor decisions and perhaps didn't know what they were doing, I'd report it to the office." The senior carer said, "I might benefit from an update on the MCA." We found care staff and senior carers would benefit from MCA training so they had a better understanding of how the Act protects anyone who lacks capacity to make certain decisions because of illness or disability. Care staff knew they could only provide care and support to people who had given their consent. One staff member said, "We can't force people to do things. We have to explain what tasks we are doing and make sure they are happy for us to help them."

If people required support with food and / or drink preparation or assistance to eat and drink this was recorded in their care plan. Although we found no detail was given about the level of support needed or what people liked to eat or drink, staff told us they asked people or their relative. However, some people that received

Requires improvement

Is the service effective?

support from the agency were unable to verbally communicate and did not always have a relative living with them, this meant that if staff did not know their preferences they would not have the information to refer to.

The senior carer told us that people could purchase additional hours from the agency at an agreed cost if they wanted a staff member to support them to a healthcare appointment. The senior carer said, "If care staff think someone is unwell and needs a GP, they will phone the office and if the person's relatives can't make the appointment we will call their surgery for them." This meant that people were supported to access healthcare services.

Good

Is the service caring?

Our findings

All of people who responded to our survey told us staff were kind and caring. People and their relatives we spoke with also told us they felt staff were kind and caring toward them. One person said, “The girl is very kind to me.” Another person told us, “The carers are very pleasant.”

People and their relatives told us that they were involved in their care and support. One relative told us, “We had a meeting with the agency at our house before they started their visits to us. We’ve felt involved.” The senior carer told us when they received an enquiry from a person or information from the Local Authority to provide care and support, they undertook an initial assessment with the person and their relatives. Care records reflected such involvement from people.

Thirty-nine per cent of people who responded to our survey told us they were not always introduced to new care staff before they were provided with care and support. Seventy-five per cent of relatives told us their family member was not introduced to staff before visits took place. One relative told us, “On the whole, my family member receives very good care. But, my family member finds it difficult to cope with the changing carers. I feel new carers should be introduced by a regular carer before visiting on their own. This would reassure my family member and also make sure the carer was familiar with my family member’s routine.” Another relative said, “They are nice carers, but sometimes we do not know who is coming and they are not introduced properly.” The registered manager told us they aimed to provide support to people from regular carer staff to maintain continuity, but this was not always possible to achieve because of unplanned sick leave or staff annual leave."

Care staff we spoke with told us they enjoyed their job. One staff member said, “It’s one of the best companies I’ve worked for. I enjoy helping older people and making them happy.” Staff said when they worked with the same people this helped them develop positive and caring relationships with the person and their relatives.

People told us staff supported them to maintain their independence. One person said, “I’ve got a painful leg, so the carers help me with anything if I have to move about or bend. Otherwise, they let me get on with things myself.” Staff told us they felt it was important to encourage people to do things for themselves wherever possible. One staff member told us, “If someone can do something such as washing a part of themselves, then we encourage this and then do the parts the person cannot manage.”

Care staff told us how they ensured people’s privacy and dignity. One person told us, “I’d describe the carers as respectful and polite.” Another person said, “They respect my privacy.” One care worker told us, “If someone needs time in the bathroom, I ask them to call me when they need support.” Care staff understood the importance of maintaining people’s confidentiality. Care staff told us they would not discuss people’s personal information with anyone unauthorised. We saw people’s personal details and care records were held securely in locked cabinets at the agency’s office, with access restricted to authorised staff.

Requires improvement

Is the service responsive?

Our findings

Ninety-six per cent of the people who responded to our survey strongly agreed that they were involved in making decisions about their care and support. One relative told us, “I remember someone came to my house to discuss the support with us. I feel the service we get responds to what we asked for.” All of the seven care records we looked at contained an initial assessment of people’s needs to determine what support they needed.

One relative told us, “My family member needs a urinal bottle leaving accessible to them but carers often forget to do this. This causes anxiety to my family member and means they cannot be independent.” Most people and their relatives told us when they had the same care staff they felt staff members knew them and were able to meet their needs. However, when different staff covered their visit, they did not always feel their needs were responded to as effectively. One relative said, “Overall we are happy with the service, but there can be a problem if different care staff visit, they don’t know my family member’s needs.” Another relative told us, “One carer arrived and had not been informed about my family member’s condition or needs.”

Although people felt involved in their support planning, we found care plans were not personalised to their needs and their personal preferences were not recorded. One staff member said, “It would be great if the care plan said, for example, [Person’s Name] likes a cup of tea, milk and two sugars or they like buttered toast and jam. It would mean we don’t have to ask people or their relative all the time.” Another staff member agreed and said, “That would be really useful, we can ask if they want a change but if they say a cup of tea then we know how they like it, rather than asking.” We discussed the level of detail in care records with the registered manager and they told us, “Most people do have mental capacity or a relative with them so they are able to tell staff.” People supported by the agency did not always have verbal communication or a relative living with them which meant staff may not always have the information they needed to effectively respond to people’s needs. People and their relatives also told us they felt they did not want to have to repeat the same information to care staff.

We found people’s care plans lacked detail about how tasks should be undertaken. We saw where people had health care conditions, there was no care plan to inform staff and tell them how to manage the condition consistently. Some information in care records was confusing. We saw one person’s care record said they had ‘dysphagia;’ (swallowing difficulties) but we later saw staff had recorded ‘no’ when asked the question; ‘Has the person any ‘swallowing difficulties’?’ We discussed this with the senior carer and they said, "I'd need to check with the other senior carer because this is a person they assessed and know. I'll check when they are next at work, so the care record is correct." One relative said, ‘My family member has dementia and staff did not know how to respond to their behaviour. There was nothing in the care plan to tell them what to do.” We found the lack of detail in care records impacted on people’s care when staff were not familiar with the person’s individual needs.

Fifty per cent of the people who responded to our survey told us they strongly agreed that staff arrived on time. Most people we spoke with told us that staff did not always stay for the agreed amount of time. Some people or their relatives said they felt carers were arriving either too early or too late for their agreed calls. One person told us, “They put me to bed too early. I’ve told them but it still happens.” One relative told us, “They have been an hour late, but I didn’t get a call to say they are running late.” We saw visit times had been discussed with people during their initial assessment and agreed to, but where changes had taken place, there was no record of people’s agreement to the changes. We looked at five people’s electronic visit records and saw that most took place within the time slot staff were allocated for the visit. But, we were unable to effectively audit whether people’s visits took place at times agreed by them because agreed visit times were not recorded on people’s care record or reviews of their care.

Where staff had reported concerns to the office staff about changes in people’s needs and a referral to health professionals was required, we saw actions were recorded. The senior carer told us, “One carer phoned the office and reported concerns about one person. We contacted the community nurse to arrange for them to visit and make a referral for a special mattress for the person.” This showed that staff concerns about people were responded to and referrals to health professionals were made.

People and their relatives told us they were asked for their feedback about the services provided. People told us they had the information they needed to contact the office to raise a concern or make a complaint if needed. Seventy-five

Requires improvement

Is the service responsive?

per cent of the people who responded to our survey told us they strongly agreed that any concerns or complaints were responded to well. Most people and their relatives we spoke with said they had no complaints but felt they could phone the office to raise a concern or complaint if they needed to. However, a few relatives said when they had raised a concern or complaint they felt they had not been responded to well.

Requires improvement

Is the service well-led?

Our findings

There was a clear management structure in place. One staff member said, “If we need support we can phone the office and speak with a senior carer, care co-coordinator or the manager.” Another staff member said, “There is an on-call system, so if I’m on an evening visit and need support I can phone a senior carer.” The operations manager told us, “I am based at the office and the registered manager splits their time between here and another service, but I can always contact them by phone if needed.” Staff told us they felt supported by team members and managers and believed that if they asked for support, this would be provided.

We received mixed feedback from people regarding whether the service was well led. One person told us, “The service is perfect, I can’t fault them.” One relative said, “The care staff are first class, but the management is not so good. Communication could be improved upon.” Another relative said, “When I’ve asked for someone to return a call to me from the office, this does not always happen.”

One staff member said, “I tend to start a bit earlier in my own time to give myself some flexibility, otherwise I can run late because we don’t get travel time.” The finance manager explained to us that visits were scheduled, by office staff, within time slots. This meant that care staff may arrive up to 15 minutes before or 15 minutes after the agreed time. A few visit records showed us that visits had taken place outside of the agreed time slot. We received mixed feedback from people when we asked if they were notified if their visit was going to be late. One person told us, "My carer will usually give me a ring if they are running late because of traffic or if something else has delayed them at their other visit." But, some people told us they were not always informed if their visit was going to be late.

We asked the finance manager about travel time been visits. The finance manager explained to us the agency worked on ‘blocks of time’. They explained the visit appeared as a ‘15 minute visit’ on staff rotas but said, “The visit could in fact be 12 minutes if staff get the tasks completed, so there is some travel time within the rota but it just does not show because of how ‘blocks of time’ are entered onto the computer.” We found that this was not an effective system of allocating staff travel time to ensure visits took place within the agreed time slots.

The finance manager told us there had been eight missed calls to people over the past four months. They said, “The risk of missed calls or lateness should be reduced because we have just implemented a call ‘alert system’ this month. It will tell us, through email and text message, if a planned visit has not taken place.” This meant office staff would be alerted so action could be taken to ensure visits to people took place as planned.

The senior carer explained that paper and electronic care records were maintained. They said, “The electronic care plan is current and there is a paper copy of that in people’s homes for staff to refer to.” We found care records, including risk assessments and medicine records, were not always up to date and did not always contain the information staff needed. We looked at audits of people’s medicine administration records and found issues we found had not always been identified. We discussed these with the senior carer and they told us, “I agree I should have identified the action needed and spoken with staff so the medicine record was detailed.” This showed us that audits of care records were not always effective.

People and their relatives were asked to give feedback about the quality of the service through an annual survey questionnaire. The registered manager told us their 2015 survey had recently been sent to people. Some responses had been received, but as the final date for returning them had not yet passed, no analysis had yet been completed. We looked at the returned 2015 survey forms and saw most people had ticked questions to indicate they were happy with the care provided. However, a few comments such as, “Overall happy with the care provided. However, sometimes not knowing which carer is due to arrive or constantly sending new staff is difficult and explaining what needs to be done.” And, “It is sad when usual carers are off, as not all other carers are as good or of such a good standard.” These comments showed us some respondents to the provider’s feedback survey felt improvement could be made to the service they received. The registered manager said, “When the feedback return date has passed, we will analyse the results and identify any actions needed.”

Systems were in place to record, investigate and analyse accidents, incidents and complaints. However, we found the system was not always followed by managers. We were aware of one accident that had occurred and found no accident or investigation record. We were aware of one

Requires improvement

Is the service well-led?

complaint that had been made and the person told us they had not received a response. We found no record of their complaint. A further relative said they had complained but had not received a response. We discussed these concerns with the registered manager and they said, "I cannot account for it. The records should have been made by the manager that received the details of the accident and complaint and should be located here."

The registered manager had sent notifications to us about important events and incidents that had occurred. We discussed a concern that had been anonymously raised with us about the confidentiality of people's personal information. The operations manager told us the provider had introduced a 'social media' policy and reminded staff about their responsibilities in keeping people's information confidential. We saw that people's personal information was stored securely at the office and access was restricted to authorised staff.