D2SCo Limited

Home Instead Senior Care (Calderdale & Spen Valley)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 1 June 2017. The provider was given 48 hours' notice of the inspection.

This was the first inspection of the service under its current registration.

Home Instead Senior Care is a domiciliary care agency which provides care services to people in their own homes. When we visited the office the registered manager told us 53 people were receiving a personal care service. The agency provides a service to adults, older people, people living with dementia, people with physical disabilities, learning disabilities, sensory impairment and people with mental health needs.

There was a registered manager in place. 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.

Most of the people we spoke with told us they felt safe. Staff knew how to report concerns about people's safety and welfare within the organisation. However, safeguarding alerts where people may have been at risk had not always been made by the registered manager and the registered manager had not routinely notified CQC of safeguarding issues.

People reported having experienced missed calls.

Medicines were not always managed safely and risks to people's safety and welfare were not always identified within care records.

Sufficient numbers of staff were deployed to provide people with the care and support they needed. The required checks were done before new staff started work and this helped to keep people safe. Staff were provided with training and support to help them carry out their roles.

Where necessary, people were supported with their nutrition and hydration. People told us how staff always made sure they had drinks available to them.

We found the service was working in accordance with the Mental Capacity Act 2005 and this helped to make sure people's rights were protected. People told us their consent was sought but we saw the consent on one occasion had been sought from people's relatives even though the person had capacity to do this

People's 'Do Not Attempt Resuscitation' (DNAR) orders were not included in their care records which meant their wishes may not be complied with.

Changes to people's needs were not always communicated to staff.

People who used the service were supported in their health and welfare needs.

People who used the service had mixed views about staff approach. Some found staff to be caring and respectful of their privacy and dignity needs but others did not.
Some people said staff communicated with them very well whilst others had experienced problems with this.

People told us staff supported them in maintaining their independence.

Some people told us they had been involved in the development and review of their care plans whilst others said they had not.

Care plans were not person centred and did not always contain the level of detail staff needed to make sure they delivered the care and support people needed at each visit.

Reviews of people's care were not always incorporated into the care plans. This meant care plans did not always reflect current needs.

There was a system in place to respond to and manage complaints. Some people we spoke with were happy about the way their complaints had been managed but others felt they had not been responded to.

There were systems in place to monitor and improve the quality and safety of the services provided. However these were not sufficiently robust and had not identified issues we found during the inspection.

People we spoke with had mixed views about the effectiveness of the management of the service.

We found two breaches of regulation. These were in relation to safe management of medicines and notification of incidents.

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.

People said they felt safe when receiving care but missed calls were not monitored appropriately.

Systems for managing medicines were not consistently safe.

Situations where people may have been at risk had not always been recognised and safeguarding referrals and relevant notifications to CQC had not always been made.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received appropriate training and support.

Staff did not always receive information about changes in people's care needs.

The service was working within the requirements of the MCA and people were asked for their consent. Systems were not in place to alert staff when people had a 'Do Not Attempt Resuscitation' (DNAR) order in place.

Is the service caring?

Requires Improvement

The service was caring but some improvements were needed.

Some people felt staff were caring but others were not happy about how staff communicated with them.

Some people felt their privacy and dignity were respected but others did not.

Care records were developed in a way which encouraged staff to be respectful and caring.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Not all people were involved in the development and review of their care plans.

Care plans were not developed with a person centred approach and did not give sufficient detail of care to be delivered at each call.

Complaints were not always managed to people's satisfaction.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems were in place to monitor the quality of the service but these were not sufficiently robust.

Not all of the people we spoke with felt the service was consistently well managed.

People who used the service and staff were consulted for their opinions about the service.

Home Instead Senior Care (Calderdale & Spen Valley)

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 1 June 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection was carried out by two adult social care inspectors and an expert by experience who did not visit the office but made telephone calls to people who used the service or their relatives. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance the expert by experience had personal experience of living with disabilities and supporting others living with disabilities and communication difficulties.

We visited the provider's office where we spoke with the registered manager, the provider, three care givers, a senior care giver, the trainer and two care co-ordinators. We looked at five people's care records, medication records, eleven staff files, training records, duty rotas and other records related to the management of the service such as meeting notes and quality assurance records. We spoke with twelve people who used the service and four relatives by telephone.

On this occasion we did not ask 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 reviewed all information we held about the provider and contacted the local authority to ask for their views on the service.

Requires Improvement

Is the service safe?

Our findings

All but two of the people we spoke with said they felt safe when staff were providing their care. However, one person told us they did not think staff used the equipment their relative needed to move safely. They told us one member of staff had hurt their relative by not using the equipment properly.

Another person told us they did not feel always safe with a particular member of staff. They said they did not think the member of staff was physically able to assist them to bathe safely so they had a wash instead.

Seven people we spoke with told us they had experienced missed calls. One person told us "Yes we have had missed calls and on two occasions I have had to do my (relative's) care because they had no one else available." Other people told us "They don't ring me and I have to ring them and by that time they can't find anyone to come which puts the burden back on me to care for my (relative)" and "Yes I have and they don't ring me, I have to ring them."

Some people told us office staff did ring to let them know and tried to cover the call but this was not always successful. One person told us "Yes I have had missed calls. They ring and let me know I won't be having a carer that day. This means I can't go and do my shopping as that is part of their duties within my care plan" and another said "Yes there has been a few mix ups. Sometimes the office will inform me when a carer is off sick and they will try their best to get someone else to come. I do manage in an emergency."

We asked the registered manager if they maintained a missed call log or had any other means of monitoring missed calls. They told us they didn't but said the electronic system let them know when a staff member had not arrived at a call and they would ring the member of staff to find out why they were late.

Following the inspection visit the registered manager sent us a missed call log which they had developed since the inspection. The call log showed ten missed calls since January 2017 but did not include any detail about how the person using the service might have been affected. The registered manager told us told us they would continue to use the log.

Staff told us calls were scheduled in ways which meant they were usually able to arrive on time. Consideration was given to distances between calls and the time taken to travel between them when schedules were produced.

The provider had systems in place to alert them when staff arrived and left a person's house, and a process to follow on occasions when staff were going to be late.

Some office staff were occasionally deployed to support staff when there were shortages, for example due to sickness. However, the registered manager told us when this happened office staff did not use the system to log in and out of the person's home.

We looked at the records of accidents, incidents, safeguarding referrals and complaints to check whether

the registered manager had notified statutory bodies such as the local authority and the CQC where required. We found a number of incidents which had been raised with safeguarding authorities had not been notified to the CQC. This is a regulatory requirement. For example, incidents relating to suspected emotional and financial abuse had not been notified to the CQC. In addition we saw some incidents reported by staff had not been recognised as indicators of potential abuse. For example, we saw one a concern raised by a relative about bruising on a person's body. We saw the failure of a staff member to report what they had seen had been investigated by the registered manager, but the causes of the bruising had not. This had not been notified as a safeguarding alert to the local authority or the CQC. We did not see evidence of any missed calls having been referred to safeguarding.

Based on evidence we had seen, we concluded the provider was in breach of Regulation 18 (Notification of other incidents) of the Health and Social Care Act 2008 (Registration) Regulations 2009.

All of the staff we spoke with told us they would raise concerns with staff at the office if they thought somebody was at risk. One staff member told us they would not hesitate to use the whistleblowing procedure if they thought their colleagues were putting people at risk.

People we spoke with were mostly happy about the way staff supported them with their medicines. One person said "My medication comes in Dosette boxes and the carers make sure I have it. They apply the creams when and where it is needed." However, one person told us "I asked for a glass of water to take my pills that she had put out, she got the water and plonked it down in front of me and said her hour was up and she promptly left. So didn't check I took my pills."

We saw from one person's care records they were using oxygen. This was not mentioned within the person's care plan and no risk assessment had been developed in relation to the oxygen.

Eye drops administered by staff were not recorded on MARs.

We looked at the MARs for a person who received pain relieving medicine through a patch applied one each week to the skin. We saw the patch was named differently on different MARs. For example it was sometimes called a 'Transdermal patch', on others it was called 'Bupenorphine patch' and on others 'Bupenorphine'. Records of application of the patch were difficult to follow and on one week the patch was recorded as administered twice. We also noted that although the MARs asked for the medication, dose and time administered to be completed; this was not always done with just the name of the medicine recorded. Where the times the medicine was to be administered was recorded, we could not see that the medicine had been given as prescribed. We also noted one week's MAR had been repeated with different signatures of administration on both.

Medication Administration Records (MARs) were audited on their return to the office. However we found the audits had failed to identify issues such as the ones described above.

We concluded medicines were not always managed safely.
This was a breach of the Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Safe management of medicines)

Care files contained some risk assessments for such as mobility and moving and handling. However, one file we looked at did not contain any risk assessments in relation to the person being blind and hard of hearing. This meant not all risks to the person's safety had been considered.....

We looked at the recruitment files of 11 staff. We saw the provider followed a structured interview process which evidence why staff were suitable for their role, and undertook identity and background checks including following up references and making checks with the Disclosure and Barring Service (DBS). The DBS is a national agency which holds information about people who may be barred from working with vulnerable people. Making these checks helps employers make safe recruitment decisions.

The ratio of staff to people was monitored during audit activity, and a member of staff told us staffing levels were considered before new people began using the service.

We saw a small team of staff were introduced to people to ensure there was flexibility and continuity of care.

Most of the people we spoke with told us they had been introduced to new staff although two people told us this did not always happen. One person said "New carers are not always introduced to us and they only shadow sometimes. It makes it difficult for my wife as she has difficulty with communication because of her dementia and it is harder when you don't know the carer."

Staff we spoke with told us they were provided with personal protective equipment (PPE) such as gloves and aprons. However some of the people we spoke with expressed concerns about standards of hygiene and infection control displayed by some staff.

One person's relative said "they shove wet nappies and pads in the nearest bin even if it is overflowing. They don't empty it or dispose of them. I go in and the various rooms where they have done this stink of urine and I have to empty the bins and clean up". Another relative told us "There appears to be a lack of general cleanliness". A person who uses the service said "I think they should wash their hands when they come in, it should be automatic but sometimes I have to tell them. It makes me feel sick if I am not sure whether their hands are clean before doing my meals."

Requires Improvement

Is the service effective?

Our findings

The provider ensured staff received a thorough induction, which included working towards the Care Certificate. This is a national set of standards which aims to equip staff with knowledge and skills they need to provide effective care and support. We saw the induction included training in areas such as safeguarding, how to identify poor nutrition and hydration, person-centred working, equality, diversity and human rights and mental capacity. Staff completed workbooks which evidenced their learning from the training, and completed shadowing sessions with senior staff.

Most of the people we spoke with confirmed that new staff were introduced to them and that they shadowed an experienced member of staff. People who used the service told us "They have introduced new carers to me and they have shadowed my regular carers", and "Yes, new carers have been introduced to me and shadow my main carer to learn what to do especially with my equipment."

However, other people told us "Occasionally someone new is introduced and shadows my main carer but not always" and "They always used to introduce new carers and they use to shadow the more regular ones but not anymore."

Training records showed staff received training and regular updates in areas including moving and handling, medication, basic life support and safety. We spoke with the person in charge of training. They were enthusiastic about their role and told us about the workbooks staff followed and about new areas of training such as a new certificate in dementia care.

We received a mixed response when we asked people who used the service if they thought staff had received the training they needed. One person said "My carer was trained to use my equipment and what was needed and when she goes on holiday any new carer is introduced to me and trained to use my equipment." Another told us "I seem to have carers who have been doing the job a long time and know what they are doing. One carer when she started with me told me that if she was doing anything wrong she wanted me to tell her so she could learn."

However other people said "Not always. Some carers are better than others especially when there are communication issues", and "The younger new carers need more training and advice on how to work with older people, they seem to shy away from touching or are adverse or not up to touching older persons and will avoid it as much as possible."

Supervision records showed staff had regular opportunities to discuss their performance, the effectiveness of training they had received and any on-going training needs, the quality of support they received from senior staff and their experience of working for Home Instead.

Staff also received an annual appraisal, which was a more detailed review of their performance and development over the year. This included the setting of personal development objectives, a review of what the staff member thought they had done well and where they felt they may benefit from additional training,

together with a review of progress towards achieving previously set objectives.

We spoke with a member of staff who told us they had recently been appointed to a role which involved them supporting staff in their practice. They told us all care givers received a 'spot check' every three months. Spot checks are when a senior member of staff turns up unannounced to observe the care being delivered in people's homes.

Some staff told us that communication within the service was not always effective. For example, two staff told us that changes to the needs of people who used the service were not always communicated to them and that staff had turned up at people's houses when the office had been informed that the person was in hospital.

Care plans included a list of people's preferences with regard to food and drink and the support they needed to maintain a healthy diet.

Most people told us they were well supported in meeting their nutritional and hydration needs. One person told us "I know what is in my fridge and tell them what I want. I have to have lots of water due to my condition and I can't have milk with my medication. They will pop into my garage and get further packs of water for me. That way they know I have plenty to drink between visits."

Others said "They always ask what we want. My daughter buys ready meals and puts them in the freezer. They tell us what is in there and we choose what we would like through day. They always ask what we like to drink and they will leave water for me to have" and "They always give me a choice and we have a discussion. They are very good at coaxing me to eat when I can't be bothered to eat. My regular carer is excellent with that. They are mostly at the right time and they make sure I have a bottle of water and fruit juices to hand before they leave."

One relative we spoke with expressed concerns as they had found food and milk left to go off in their relation's fridge.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In the case of Domiciliary Care, applications must be made to the Court of Protection. We were not made aware of any people currently using the service for whom such an application had been made.

Care records showed people's capacity was assessed where needed.

Care records showed that people's consent was sought for such as administration of medicines. However we noted one of these had been signed by a relative even though the information in the person's file said they had full capacity. Following the inspection the provider informed us that his consent form had been subsequently superseded by the new client consent form which was signed by the client. This had not been seen by the inspector. The provider informed us that all old consent forms had been removed from files to avoid confusion.

People who used the service told us staff did seek their consent. They told us "They do ask me what I want them to do and how I would like them to do it" and "They will always give me a choice of what I would like doing and how. When it is my social activity time they will give me a choice of what can be done within the time allocated."

We noted the care records for a person diagnosed with a terminal illness did not include a 'Do Not Attempt Resuscitation' (DNAR) order. When we asked the registered manager about this they told us they had been advised by the national office that DNAR forms must not be included within people's care files and it must not be recorded in people's care plans that they had a DNAR in place.

We were concerned that this could result in a person's wishes not being met.

People we spoke with told us staff would alert healthcare professionals if necessary. One person told us "My regular carer will sit down with me when I am not well in order to find out what is wrong and she will ring the office to ask them to notify my daughter. She will also ring my GP if necessary." Another said "One carer rang my GP who told her to call an ambulance for me. She stayed with me until the ambulance came and informed my son I was going to the hospital."

We saw people's care records included a list of people involved in the person's care such as GP, district nurse, social worker and their telephone numbers. Numbers for people's relatives were also included so that staff could contact them in an emergency.

Requires Improvement

Is the service caring?

Our findings

Many of the people we spoke with felt staff were caring in their approach.

They told us "My (relative) has dementia and is frightened all the time. They are really good at caring for (them) and trying to put (them) at ease", "I get on really well with my carer we have a laugh and a joke and a common interest in football. It is fantastic. She is so sympathetic when I am in pain, I feel okay to talk to about some aspects of my health issues but not all of them." and "Before I wasn't able to go out but now I can and it is especially good as I they now take me to visit my (relative) who has dementia. The carer stays with me and is fantastic with my (relative) as well."

However others did not feel staff were always caring. They told us "My care varies; communication appears to be an issue throughout the company. Some don't talk to me. You can't build a rapport with them. I have had one or two carers in the past it has been terrible and I can't wait for them to go", "Not always. Some carers are better than others especially when there are communication issues. Some will talk but we have had carers tell us they don't have time to talk to us. Some are not as friendly as we would like, I get depressed about it" and "I have made a few friends of the carers and we have a laugh and a joke but not with the new ones as I have to get used to them, especially as some are not very good at engaging with you."

When we asked people if they felt staff met their dignity needs we received a mixed response. Some told us staff were very good, for example one person said "They are very good and very polite. When doing my personal care they always cover my bottom half when doing the top and vice versa. If I am in the bathroom when they arrive they always shout out hello and I tell them where I am and if I need help." Other people gave us examples of how staff closed doors and curtains and made sure people are covered during personal cares.

However two people said "They do not respect my (relative) dignity", this was in relation to managing continence needs discreetly. Another person said "I wouldn't like to say that the carers treat my (relative) with dignity and respect" but did not give specific examples.

People told us staff encouraged them with their independence wherever possible and said they took time and were patient in doing do.

Staff we spoke with were enthusiastic about providing people with good care and told us they enjoyed being able to spend time with people.

One member of staff told us about a person who did not communicate well in English. They told us a colleague who spoke the same language had written a few phrases in the person's care plan so that staff were able to have some basic communication with the person.

Relatives of people living with dementia praised the staff. One person told us "Although my (relative) can't speak they do talk to him. They also talk to me and make sure (relative) is okay" and "Communication isn't

all that great as my (relative) has dementia and finds it difficult to communicate. She does seem to get on really well with the current carer. The carers do try and communicate with her but it is difficult." Another person told us how staff reassure their relative when, due to their dementia, they were frightened and confused.

Care records were written in a way which encouraged staff to be respectful and caring and included detail about people's backgrounds and their interests and preferences.

Requires Improvement

Is the service responsive?

Our findings

We found care records contained good detail in relation to the support people needed in areas such as moving and handling and personal care needs. However we found they lacked specific detail as to the care to be delivered at each visit. When we asked care staff about this they agreed they would struggle to follow them if they had not delivered care to the person involved previously but said that didn't happen as they had always been introduced to the person previously and had visited them with a colleague familiar with their care needs.

However some of the people we spoke with said this was not always the case. One person said "Occasionally someone new is introduced and shadows my main carer but not always. When there was a problem a senior carer came in who I had never met before." And "New carers are not always introduced to us and they only shadow sometimes.

We found care plans lacked a person centred approach and there was little evidence of the person concerned, or, where appropriate, their relatives having been involved in their development.

When we asked people about this we received a mixed response with some people saying they had been involved and others saying they had not. One person told us "I was involved in the setting of my care plan and I would have thought they will involve me in setting up a new care plan once I have had my operation." However another person told us "My care needs have changed but no one has changed the care plan so currently my needs have not been met."

One of the care plans we looked at was for a person who had been receiving care from the service for a year. The care plan had been reviewed after six months but the review was incomplete and although the person's needs had changed, this had not been incorporated into their care plan. The registered manager agreed the care plan was out of date.

Some of the people we spoke with told us staff did come out to review their care needs with them. One person said "I have had a review every three months. We have discussed issues and sometimes improvements happen." However others told us they had not had a review "We were told we would get a review but we haven't."

The provider had a policy in place which showed how complaints would be managed. We saw this process was followed. Complaints received were logged, and we were able to see what action had been taken as a result. We noted in one case people had expressed concern about a lack of acknowledgment of their initial contact, however we saw the registered manager and provider had responded and ensured the people received information relating to the investigation of their complaint.

When we asked people about raising complaints with the service we received a mixed response. Some people told us they had raised complaints which had been addressed and staff from the office had been to visit them to discuss their concerns. However others told us they had not received a satisfactory response.

One person said "I have made my views known but promises made to rectify the situation has not materialised."

Requires Improvement

Is the service well-led?

Our findings

Home Instead is a national organisation which franchises its policies, procedures and branding to individual providers.

There was a registered manager in post when we inspected this service, and they had the support of the director in running the service. In addition there was a large administrative team including care co-ordinators, a trainer and a call scheduler. During the inspection we were given good access to documentation and the people we needed to speak with.

There were systems put in place by the brand owner for quality monitoring in the service. These included audits of care records, recruitment and surveys of people who used the service and staff. Following an audit visit we saw action plans were developed to ensure improvements were made as needed. These showed clearly who had responsibility for leading change, and the date by which actions should be completed.

The registered manager and provider told us they met regularly to discuss the performance of the service, however when we asked to see minutes of these meetings we were told they were not kept. The provider sent us a copy of an audit from the national office dated October 2016 which included an action plan detailing actions identified to improve the service. Quality was also monitored through regular spot checking of staff to ensure their practice met people's needs safely. Staff and people who used the service confirmed spot checks had taken place.

Some aspects of the service were not robustly monitored. For example, accidents and incident information was not collated and analysed to enable the registered manager to identify and address any emerging trends. Carrying out such checks may have enabled the registered manager and provider to identify the safeguarding alerts which should have been raised. Similarly there was no analysis of complaints and concerns or call performance. We discussed improvements that could be made with the registered manager and provider. They told us they had concentrated their efforts on ensuring the systems to deliver care and support were robust, and would address quality monitoring following our visit.

Following the inspection visit, the registered manager shared with us an analysis of missed calls which they had developed. This showed they had already responded to some of our findings.

We recommend the provider continues to develop a robust system of auditing the quality of the service.

When we asked people about the management of the service we received a very mixed response. One person said "I think it is well managed but as this is my first experience of receiving care I don't have anything else to compare it with" and another said "I know the managers and can relate to them. I have a reasonable rapport with them." Other people told us "The service has gone downhill lately and requires improvement. I don't know the managers but the service provided needs improvement", "At times the management is chaotic…things are not dealt with properly" and "It is easy to get through to the office but messages are not passed on or dealt with appropriately. The management and office system let the service

done. My (relative) and I are reasonably happy with the service we get from the carers but not from the office or the management."

People who used the service and staff were surveyed annually, and we saw the feedback had been analysed and an action plan produced. For example, staff had fed back that call planning could improve, and we saw action had been taken to address this. Staff also had the opportunity to attend team meetings with the registered manager. We looked at the minutes of the most recent meetings and saw there had been introductions to new office based staff and a discussion about operational issues which had impacted on quality in the service.

One member of staff we spoke with told us they were not always able to attend meetings due to their work pattern. They said they did not get copies of minutes of meetings they had not attended.

All of the staff we spoke with told us they enjoyed working for the service. One person said they had raised some issues with the manager and they had responded well. Another person said "They are a really good company to work for; they care about us caregivers as well as clients."

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 18 Registration Regulations 2009 Notifications of other incidents Incidents which had been raised with safeguarding authorities had not been notified to the CQC

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely