Homestay Care Ltd

Homestay Care Limited

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection visit took place on 20 September 2016 and was announced. The provider was given four days' notice of our inspection visit to ensure the manager and care staff were available when we visited the agency's office.

The service was last inspected in September 2013 when we found the provider was compliant with the essential standards described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Homestay Care provides domiciliary support for people of all ages and abilities who live in their own homes. Most people received support and care with several visits each day. On the day of our inspection visit the service was providing support to 112 people.

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

We found the provider had not notified us of all the important events that occurred at the service. For example, the deaths of people who used the service and allegations of abuse.

Medicine procedures required improvement to ensure care staff recorded the administration of all prescribed medicines. Medicine auditing procedures were not always sufficiently detailed to ensure issues for improvement were identified. For example, audits had not identified where staff were not following the provider's policies and procedures for the recording of medicines.

The manager understood the principles of the Mental Capacity Act (MCA), and staff respected people's decisions and gained people's consent before they provided personal care. However, mental capacity assessments were not always clearly documented, where people lacked the capacity to make all of their own decisions. A new format for recording mental capacity assessments and best interest decisions was being implemented at the time of our inspection visit.

People felt safe using the service and there were processes to minimise risks to people's safety. These included procedures to manage identified risks with people's care. Staff understood how to protect people from abuse and keep people safe. The character and suitability of staff was checked during recruitment procedures to make sure, as far as possible, they were safe to work with people who used the service.

There was enough staff to deliver the care and support people required. People told us staff were kind and knew how people liked to receive their care. Staff received an induction when they started working for the service and completed regular training to support them in meeting people's needs effectively. Although the

manager did not keep a current record of staff's training this was being developed. People told us staff had the right skills to provide the care and support they required.

Care records were detailed and provided staff with accurate information on how they should support people, according to their preferences. Care reviews were undertaken each year, or when people's needs changed to ensure support continued to meet people's needs.

People told us the manager was approachable. Staff were supported by managers through regular meetings. There was an 'out of hours' on call system in operation which ensured management support and advice was always available for staff.

Quality assurance systems were in place to assess and monitor the quality of the service. There was regular communication with people and staff whose views were gained in relation to how the service was run; their views were used to make improvements.

People knew how to complain and information about making a complaint was available for people. The provider monitored complaints to identify any trends and patterns, and made changes to the service in response to complaints.

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.

Medicine procedures required improvement to ensure people received all their prescribed medicines. People felt safe with care staff. Care staff understood their responsibility to keep people safe and to report any suspected abuse. There were enough care staff to provide the support people required and staff had been recruited safely to ensure they were of good character to work with people in their own homes.

Is the service effective?

Good

The service was effective.

Care staff completed induction and training and were supervised to ensure they had the right skills and knowledge to support people effectively. Staff understood the principles of the Mental Capacity Act (2005) and care staff respected decisions people made about their care. People who required assistance with their nutritional needs received support to prepare food and drinks, and people were supported to access healthcare services.

Is the service caring?

Good

The service was caring.

People received care and support from regular care staff that understood their individual needs. Staff were caring, respected people's privacy and promoted their independence.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in decisions about their care and how they wanted to be supported. People's care needs were assessed and people received a service that was based on their personal preferences. People knew how to make a complaint. The management team responded to feedback and acted on this to improve the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had failed to notify us of specific events at the service, as is their legal requirement. Auditing procedures required improvement to ensure staff followed the provider's policies and procedures. However, people told us they knew who to contact in the office if they needed to speak with a manager. People and relatives were satisfied with the care and support they received.

Homestay Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection visit took place on 20 September 2016 and was announced. This service was inspected by one inspector and an expert by experience. An expert-by-experience is someone who has personal experience of using, or caring for someone who has used this type of service.

The provider was given four days' notice of our inspection visit because the agency provides care to people in their own homes. The notice period gave the manager time to arrange for us to speak with them and staff who worked for the service.

We reviewed information received about the service, for example the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Before the inspection the provider completed 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 found the PIR reflected the service provided at the time of submission. We also contacted the local authority commissioners to find out their views of the service. These are people who contract care and support services paid for by the local authority. They had no concerns about the service.

Before our inspection visit we reviewed information people had sent to us regarding the service, through our 'share your experience' form on our website. During our inspection visit we spoke with the registered manager, the training assessor, a care co-ordinator and two care staff. After our inspection visit we telephoned thirteen people, six people who used the service and three people's relatives provided us with feedback.

We reviewed four people's care records to see how their care and support was planned and delivered. We checked whether staff had been recruited safely and were trained to deliver the care and support people

required. We looked at other records related to people's care and how the service operated including the service's quality assurance audits and records of complaints.

Requires Improvement

Is the service safe?

Our findings

All of the people we spoke with said they felt safe with staff. Comments included; "Yes I feel safe with them all", "Yes I do, because they are local people (and I know them)", "I'm happy with them. They're nice girls."

People were supported by staff who understood their needs and knew how to protect people from the risk of abuse. Staff attended safeguarding training. This training included information on how staff could raise issues with the provider and other agencies if they were concerned about the risk of abuse. Staff told us the training assisted them to identify different types of abuse and they would not hesitate to inform the manager if they had any concerns about anyone's safety. However, we found the provider did not have a procedure in place to notify us, when they made referrals to the local authority safeguarding team and where an investigation was required. We have asked the provider to notify us of all safeguarding concerns in the future.

The provider's recruitment process ensured risks to people's safety were minimised. The provider's recruitment procedures ensured staff were of a suitable character to work with people in their own homes. Staff told us and records confirmed, they had their Disclosure and Barring Service (DBS) checks and references in place before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services.

There was a procedure to identify and manage risks associated with people's care. People had an assessment of their care needs completed at the start of the service that identified any potential risks to providing their care and support. For example, one person who was at risk of falling had a risk assessment in place for managing their mobility. Care records instructed staff on how the person should be assisted to move safely.

People and staff told us there were enough staff to meet people's needs and attend all the scheduled calls on time. One person said, "The timekeeping's fine and I've no complaints." The manager and care co-ordinator responsible for scheduling calls confirmed there were enough staff to cover all the calls people required. The manager explained they had recently recruited more staff to ensure they had an adequate staffing team, to allow for sickness and staff turnover. The manager said they were able to attend calls and perform care duties, along with other office based staff, if this was required, as they kept their training and knowledge up to date. This meant additional contingency staff were available to allow for staff sickness and emergencies.

The manager operated a call monitoring system which meant care staff logged in when they arrived at people's home, and logged out when they left. This system alerted the manager when staff had not arrived at a person's home within 15 minutes of their agreed call time. The manager was therefore able to monitor where staff were, and arrange alternative care staff to attend people's homes if staff were running late. The manager and care co-ordinator scheduled travelling time between calls to minimise the risk of staff arriving late to attend calls.

Most people we spoke with administered their own medicines or their relatives helped them with this. People who received support with medicines told us they received their prescribed medicines safely. One person commented, "They (staff) check to make sure I've taken it." Another person said, "They administer eye drops for me." They indicated the system worked well for them.

Staff told us they administered medicines to people as prescribed. Staff received training in the effective administration of medicines which included regular checks by the manager on staff's competency to give medicines safely. Staff recorded in people's records that medicines had been given and signed a medicine administration record (MAR) sheet to confirm this. Completed MARs were checked for any gaps or errors by staff during visits and by senior staff during spot checks. Completed MARs were returned to the office every month for auditing.

We looked at how medicines were managed and found they were not always administered safely. We reviewed the MAR for three people. We found specific instructions in how to administer some types of medicines had not been transferred from the medicine packaging to the MAR. As some people received their medicines via a 'blister pack' which was pre-prepared by their pharmacy, this meant staff did not always have the manufacturer's guidelines available on the box of medicine. This meant they did not always have the information they needed to administer medicines safely and in accordance with the manufacturer's guidance. For example, the MAR did not include instructions on when medicines should be given before food, or with water. The MAR did not give instructions on how much time should be allowed between doses of pain relief medicine, or how much medicine was safe to administer within a 24 hour period. This posed a risk that some people could receive an overdose of medicine. For those people who received their medicines in 'blister packs' there was no list of the medicines that were prescribed by the pharmacy on the MAR.

In one person's MAR we found two of their medicines were written in the same part of the MAR, there was no space on the MAR to record when each of the medicines had been given. This meant we could not be sure the person was receiving both their prescribed medicines. We spoke with a member of staff involved in the administration of these medicines, they explained both of the medicines were always given. They added they would always update the daily records or MAR to show if either medicine had not been given.

There was no place on the MAR to indicate the time some doses of medicines were administered, for example, pain relief medicines. This was important, as some people received medicines that needed a specific amount of time between doses. We checked the daily records to see whether staff noted the time the medicine was given; we found this was not done consistently. Therefore arriving staff would not always know when the person's previous dose of medicine had been given. We spoke with a member of staff who administered these types of medicines. They stated they would check visits to the person were at least four hours apart before giving the medicines. However, we could not be sure all staff were acting consistently in this way.

We found the provider had policies and procedures in place for medicines administration that were not being followed. For example, the medicines policy clearly stated staff should record the time of each dose of medicine (where medicines required a gap between doses). The provider's auditing procedures had not identified staff were acting outside the policy guidance.

We brought this to the attention of the training assessor and manager during our inspection visit. They explained they were introducing a new version of the MAR which would include more space for medicines instructions (manufacturer's guidelines). They also intended to include a section on the MAR to include comments from staff and the times medicines were given. They explained this new system would be

implemented straight away following our inspection visit. The provider later confirmed this had been done saying, "The MAR charts have now been changed, taking into consideration all the factors identified."

Good

Is the service effective?

Our findings

All of the people we spoke with told us staff had the skills they needed to support them effectively. Comments from people included; "Yes they do, they also have the right kind of person", "They are good at remembering what to do."

One person told us how staff put their training into practice to help them move around safely, they explained staff had specific training in their home to assist them to move using the person's own equipment. They added, "I feel comfortable with them."

Staff told us they were given an induction programme and training to ensure they had the skills they needed to support people. Staff told us their induction included working alongside an experienced member of staff, and training courses tailored to meet the needs of people they supported. The induction training was based on the 'Skills for Care' standards and contained a qualification at the end of the induction programme called the 'Care Certificate'. Skills for Care are an organisation that sets standards for the training of care staff in the UK. The 'Care Certificate' offered staff a recognised level of skill at the end of the induction programme.

Staff told us in addition to completing the induction programme; they had a probationary period and were regularly assessed to check they had the right skills and attitudes required to support people. Probationary periods were usually for a six month period, or were continued until staff were competent in their role. Checks on staff's competency were completed every three months to ensure they continued to have the right skills and attitudes.

The manager and training assessor were developing a database of staff training at the time of our inspection visit, which would record the training each staff member had undertaken, and alert the manager when refresher training was due to be renewed. Although we were unable to review a record of staff training, staff told us they received regular training to keep their skills up to date. One staff member said, "We can have any training we need to support people. I recently had training in using a feeding tube, to assist someone to take medicines through the tube." Staff told us they were encouraged to take a nationally recognised qualification in care, which added to their knowledge and skills.

Staff told us they had regular meetings with their manager to make sure they understood their role. Regular checks on staff competency were discussed at these meetings, and staff had an opportunity to raise any issues of concern. Staff had an annual appraisal to review their performance, discuss their objectives and plan any personal development requirements.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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.

There were policies and procedures in place which clearly described how the MCA should be applied to people's care. The provider had developed paperwork to document mental capacity assessments and best interests decisions, however, these had not yet been implemented. The manager understood their responsibilities under the MCA and could describe how best interests decisions would be made with the advice of health and social care professionals. They told us there was no one using the service at the time of our inspection visit that lacked the capacity to make all of their own decisions. Some people lacked capacity to make certain complex decisions, for example how they managed their finances. Those people had somebody who could support them to make decisions in their best interest, for example a relative or advocate.

Staff had not received specific training in the MCA. However, the manager had implemented the 'Care Certificate', which included fundamental training in MCA. Staff we spoke with knew they should assume people had the capacity to make their own decisions, unless it was established they could not. Staff knew they should seek people's consent before providing care and support. Staff said the people they supported could generally make everyday decisions for themselves. We asked people if staff asked for their consent before they provided care, they said they did.

No one had a DoLS in place at the time of our inspection visit. The manager understood their responsibility to ensure anyone being deprived of their liberty should be referred to the local authority to ensure their rights were protected.

People had choice and flexibility about the meals they ate. People could choose to prepare and cook food in their own home, or staff supported them to prepare their meals. Everyone we spoke with was satisfied about how staff supported them with their meals. One person commented, "They make my breakfast for me and they give me a choice. It's very good."

Staff and people told us Homestay Care worked well with other health and social care professionals to support people. Referrals were made to health professionals such as doctors, speech and language therapists, and the district nursing team where a need was identified. We saw staff worked with health professionals, such as the district nursing team, to monitor people's skin and report back to them regarding any changes. One person told us they felt sure the staff team would make any phone calls or referrals to health professionals if this was needed, but said they hadn't required this type of support from staff.

Good

Is the service caring?

Our findings

Everyone told us staff had a caring attitude and treated them with respect and dignity. Typical comments included; "They are very caring", "They're very good. They're very kind and speak to you as a person." Another person said, "They're just friendly enough. They are very pleasant."

People told us using Homestay Care helped them to maintain independent living, rather than being in a residential care home. They explained this was important to them, as they wanted to live their own lives. Staff told us they supported people to maintain their independence whilst providing care and support. They did this by encouraging people to do as much as they could for themselves. One person said, "Yes I think they help me to maintain my independence (by only helping me with the things I need help with)." One person told us this approach worked well for them saying, "I am confident that help is available if I need it." Staff gave us an example of one person who was unable to open their medicines due to their medical condition; staff opened the medicines, but placed these out for the person so they could take their own medicines. They said, "They put it out for me so I can take it."

People were cared for by a consistent team of staff, which helped them feel secure and maintained a continuity of care. One relative said, "We've no issues. [Name] has just two regular carers." The manager explained each person had an allocated staff team to support them, staff were matched with people according to their personality, ages, cultural backgrounds and gender preferences. Staff had a good understanding of people's care and support needs, because they supported the same people regularly so they knew people's likes and preferences. One relative told us, "They (staff) have built a relationship with [Name] and really talk to them." A member of staff told us, "We usually support the same people and get to know them really well."

People told us staff treated them with respect and dignity. They told us staff asked them how they wanted to be supported, and respected their decisions. One person said, "They check things out with me." Another person said, "It works very well. They're very good and very helpful. They wash my hair for me. I couldn't do without them and I'd recommend them."

People told us staff maintained their privacy when supporting them with personal care. This included staff knocking on people's doors before entering, and respecting when people needed private time. One person said, "They do things like close doors."

The provider ensured confidential information about people was not accessible to unauthorised individuals. Records were kept securely so that personal information about people was protected. People had a copy of their care records in their home and could choose who had access to these.

Good

Is the service responsive?

Our findings

People told us their support needs had been discussed and agreed with them and their representatives when they started using Homestay Care. One person commented, "From when I was first 'taken on', they provided a service based on what I needed, not what they thought I needed." People told us they continued to be consulted about how they liked to receive their care through conversations with staff and regular reviews of their care needs. One person said, "I feel in control (of how the care is provided)." Another person said, "They always ask if there's anything I need help with." Care reviews were usually done annually, or when there was a change to someone's condition. The reviews involved the person, their representatives, and health professionals where needed.

People told us they were supported to go out, according to their individual care package. This helped them to maintain links with family and friends and take part in events and activities they enjoyed. One relative commented, "They take [Name] to do activities they like in the community, for example, the gym and the cinema."

Care records were detailed and provided staff with the information they needed to support people. They were signed by the person, or their representative where they were unable to sign records themselves. Information in care records detailed people's likes and dislikes and included information about the person's life history and health. We found the care people received differed from person to person, with each person having an opportunity to express their wishes over how their care was delivered, for example, if people wanted to receive care from staff of a specific gender. The manager confirmed these requests were fulfilled. They said, "We only take on care packages where we have the appropriate gender of staff in place to support people."

Staff told us they had an opportunity to read care records and daily records at the start of each visit to a person's home. These daily records provided staff with 'handover' information from the previous member of staff. Staff explained the daily records supported them to provide responsive care for people because the information kept them up to date with any changes to people's health or care needs.

People told us they knew who to talk with if they were unhappy or wanted to make a complaint. Most of the people we spoke with told us they never needed to make a complaint, with a typical comment being; "We've no concerns at all."

People had a copy of the complaints procedure in the guide each person had in their home. There were procedures in place to log and analyse complaints and feedback, to see if there were any common trends or patterns. This enabled the provider to learn from the feedback they received. The manager told us, "Whenever we have contact with people we ask for their feedback. Any concerns are noted as verbal complaints and are tracked in the same way as formal written complaints; this is to ensure we are offering the best service we can."

Complaints were fully investigated by the manager to establish whether improvements to their service

needed to be made. Records showed people who made complaints were contacted in a timely way to address their concerns and try and resolve things to their satisfaction. For example, one person had raised a concern about a staff member who had filled in some daily care records. The manager had arranged to speak with the person and the member of staff. The manager reviewed the records and the daily records which were adjusted to ensure they were accurate.

One person told us about a time when their relation was not feeling happy with a member of staff. , This was communicated to the manager and the person no longer visits them. They were happy with the way this had been dealt with, clarifying that they didn't consider this to be a complaint, and indicated it was resolved effectively with no impact on their 'care experience'.

Requires Improvement

Is the service well-led?

Our findings

We reviewed information received about the service before our inspection visit, for example the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We found the provider had not notified us of all the important events that occurred at the service. For example, the provider had not notified us of any deaths of people who used their service, or allegations of abuse. We spoke with the manager regarding the lack of notifications we had received. The manager agreed to notify us of all such events in the future, and to notify us of any events which they felt we should be informed retrospectively.

People and their relatives told us the service was well managed and the manager and staff were approachable. One relative said, "The care [Name] is getting is very good. Everything is going fine and we are happy."

The service had a registered manager at the time of our inspection visit. The registered manager was supported by a management team that consisted of a care co-ordinator, a finance director, and an operations director. Three team leaders offered support to staff with their everyday work, and conducted assessments and reviews of people's care packages. The manager, care co-ordinator and team leaders worked alongside staff delivering care to people. This enabled them to check on staff performance, and keep up to date with people's care and support needs.

Staff told us they received regular support and advice from managers via the telephone and face to face meetings. Staff were able to access support and information from managers at all times as the service operated an open door policy, and an out of office hours' advice and support telephone line. These procedures supported staff in delivering consistent and safe care to people.

We asked staff if anything at the service could be improved. Most of the staff we spoke with told us they enjoyed their role, but said some things could be improved. For example, the provider did not pay staff travelling time between scheduled calls, for attendance at staff training, or for attendance at team meetings and visits to the office. We brought this to the attention of the manager during our inspection visit who told us they would discuss these issues with the provider.

Staff said the manager and provider encouraged staff to provide feedback about their work, and to raise ideas to improve the service. They did this during staff meetings, but also as part of their daily communication with team leaders and the manager. One member of staff told us they had raised issues regarding the current MAR, and a new version of the form had been developed and was being implemented.

The provider's quality assurance system included asking people, visitors and relatives about their views of the service. A yearly quality assurance survey was undertaken asking people what they thought of their care. Managers and senior staff also visited people in their own homes to observe how the staff delivered the care they received, and asked them for feedback during their visits. People told us they were also asked for their feedback when they spoke with the manager on the telephone. Any requests people had made to improve

the service were followed up by the manager. One person said, "They phone us up and chat things through."

There was a system of internal audits and checks completed to ensure the safety and quality of service was maintained. The provider directed the manager to conduct regular checks on the quality of the service in a number of areas. For example, the manager conducted checks in staff timekeeping, medicines administration and care records. Where issues for improvement were identified actions were put into an action plan, which was monitored for its completion. Some auditing procedures however needed improvement to ensure people were receiving the care they needed. For example, auditing procedures for medicines administration had not identified that staff were not following agreed policies and procedures.

The manager's role included checking staff monitored and reported on people's care and any incidents that occurred, to make sure appropriate action was taken when necessary. Records showed, for example, accidents and incidents were recorded by the individual affected, the time and location of the incident, the possible causes and the actions taken. Actions taken as a result of analysis included referring individuals to other health professionals where needed.