At Home Support Services Limited

Blu Ray House

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

At Home Support Service (Blu Ray House) is a domiciliary care agency based in Enfield, North London and provides personal care to people living in Hertfordshire and Essex.

This was an announced inspection and the service was given 48 hours' notice. This was to ensure that the registered manager would be available at the office to provide us with the necessary information to conduct the inspection.

This inspection was the first inspection of the service since it was registered with the Care Quality Commission (CQC) in February 2016.

At the time of the inspection there were 32 people using the service. The service provides personal care to older people some of whom are living with dementia or have physical disabilities.

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.

Medicines were not always safely managed. Medicine Administration Records (MAR) contained gaps and recording errors.

We received concerning feedback about staffing levels and punctuality. The registered manager was in the process of implementing electronic call monitoring system. However, current management oversight of late and missed calls was inconsistent.

Complaints were investigated and analysed for trends for improvement. However, people and relatives told us that their complaints regarding late and missed calls had not resulted in improvements to the service they received.

People and relatives told us they felt safe. Procedures and policies relating to safeguarding people from harm were in place and accessible to staff. Staff demonstrated an understanding of the types of abuse to look out for and how to raise safeguarding concerns.

We saw evidence of a staff induction and on-going training programme. Staff were safely recruited with necessary pre-employment checks carried out. However, we found instances of insufficient documented referencing. Staff received regular supervisions.

We received positive feedback from most people and relatives who told us staff were caring and responsive to their needs.

We found that care plans were person centred. Care plans provided appropriate guidance to enable staff to deliver person centred care in line with people's needs and preferences.

The provider obtained consent for care in accordance with the Mental Capacity Act 2005.

There were quality assurance measures in place, such as regular spot checks and feedback surveys. An action plan identified areas for improvement for the service such as electronic call monitoring and improved management of medicines.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Medicines were not always recorded or monitored safely.

Risk assessments were in place for people who used the service.

We received consistent feedback from people and relatives that they experienced late calls on a regular basis.

Recruitment checks were in place. However, reference checks were not always appropriately completed.

Staff were aware of different types of abuse and what steps they would take if they had safeguarding concerns. However, some staff were not aware they could report concerns to external agencies.

Is the service effective?

Good

The service was effective. Staff had access to regular training and supervisions which supported them to carry out their role.

Staff understood the importance of obtaining consent before providing care. Consent to care was appropriately documented in people's care records.

People were given the assistance they required to access healthcare services and maintain good health.

People's dietary needs and food preferences were recorded in their care records.

Is the service caring?

Good

The service was caring. People and relatives spoke positively about staff.

People were treated with dignity and respect.

People told us they were supported to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were person centred.

People's needs and wishes from the service were assessed and support was planned in line with their needs.

People using the service told us they knew how to complain if they were not happy with any aspect of the care and support they received. However, people and relatives told us that their complaints regarding late visits had not resulted in an improvement.

Is the service well-led?

Requires Improvement

The service was not always well-led. Quality assurance systems were in place to ensure quality of care. However, we received consistent feedback from people and relatives that late and occasional missed calls were a concern which had not improved despite complaints made.

We received mixed feedback from people and relatives regarding the overall provision of the service. Staff spoke positively of the management support in place.

The registered manager was implementing an action plan to make improvements to the service.

Blu Ray House

Detailed findings

Background to this inspection

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

This inspection took place on 20 and 22 June 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the registered manager would be present. The inspection was carried out by one inspector. The inspector was supported by an expert by experience who obtained telephone feedback from people and relatives. An expert by experience is a person who has personal experience of using or caring for someone who has used or uses this type of care service

Before the inspection we reviewed relevant information that we had about the provider which included safeguarding alerts and other notifications.

During the inspection we spoke to eleven people who used the service, four relatives and one healthcare professional. We also spoke with four support staff, care co-ordinator, the registered manager and the responsible individual.

We spent some time looking at documents and records that related to people's care and the management of the service. We looked at six people's care plans and risk assessments. We reviewed eight staff files. We looked at other documents held at the home such as medicines and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they felt safe when using the service. Comments received from people included, "I have never worried about the carer abusing me in any way" and "Yes very much so. The carers are really good." A relative told us, "Yes we do feel she is safe when they arrive." Despite the positive feedback received, we found that there were aspects of the service that were not always safe.

We looked at the arrangements in place to ensure people received their medicines safely when needed. During the inspection we looked at Medicines Administration Records (MAR's) for four people who used the service. The registered manager told us that MAR's were returned to the office on a monthly basis and were quality checked by the registered manager or care coordinator. Where medicines were administered from a blister pack, the individual name of the medicine, dose and frequency prescribed was not detailed on the MAR chart. Staff administering medicines in the person's MAR noted the quantity of tablets administered. MAR charts are the formal record of administration of medicine within the care setting. People's care plans noted the list of medicines the person was currently prescribed. The registered manager told us that people's medicines lists were updated on a monthly basis as part of the monthly care plan review process.

We found that some MAR's contained numerous gaps in recording and codes were not always used. Codes on MARs are used to record why a medicine may not have been administered where a letter corresponds to a particular situation. One person's MAR for the month of March 2017 contained 13 gaps in recording. The person had been prescribed medicines three times per day. We cross-checked the MAR with the person's daily progress notes and found that on some of the occasions, staff had noted that they had administered medicines. However, this was not always the case and staff had not recorded anywhere that medicines had been administered to the person in line with their identified support needs. Records were also unclear about whether staff were supporting this person with their medicines by administering or prompting as codes on the person's MAR stated that staff were both administering and prompting the person.

Where staff administered medicines to people which were not in a blister pack, a separate MAR chart was used which was transcribed by the service. One person's MAR had been completed for the administration of a blood thinning medicine which had a variable prescription. The person had been prescribed a different quantity of the medicine on week days and at weekends. We saw that on one occasion in March 2017 the person's MAR was completed by a staff member to note administration of the weekend's dose of the medicine on a weekday which meant that they could have received an incorrect dose of the medicine. We spoke to the provider and registered manager about this and they told us that they no longer supported the person with the administration of this medicine as the family had taken over this aspect of the medicines management. We showed our findings to the registered manager who assured us that people had received their medicines as prescribed and the concerns noted were recording errors.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff had received training in medicines management from the registered manager when they first

commenced employment. We asked about whether following training, staff had their competencies in medicines administration assessed. The registered manager told us that they were in the process of completing competency assessments for staff which included the completion of an assessment workbook.

We received consistently concerning comments from people and relatives regarding staffing levels and late calls. Comments received from people included, "No they are usually more late than anything. They can be a few hours late. No they don't call", "They are late quite often but it is not something I am worried about. No I don't think I have ever gotten a phone call", "They are usually late. No one calls me" and "In the morning they are usually fine but the other times they can be late. I have had to wait up to three hours. No they don't call."

Comments received from relatives included, "The problem is they don't turn up on time and she has to wait for a long time for them to get here", "They really need to improve their timekeeping. Everything else is good and she is safe when they get there", "This is something they definitely need to improve. My mum has three calls a day and they are late at least once a day and they don't even call to let you know what is happening" and "They are never on time I don't think it has happened once. Most of the time it is only 10 or 15 minutes but it can be hours." A healthcare professional told us, "When they are here it is fine, however, she has not had a carer come around at night and has spent the night in a wheelchair as she is unable to get into bed on her own." This particular feedback was identified as a safeguarding concern and a safeguarding alert was sent to the local safeguarding authority by the registered manager during the inspection.

We discussed with the registered manager and care co-ordinator how rotas were managed and how late or missed calls were monitored. The service employed 16 carers split into four teams, each covering a small geographical area. The care coordinator told us and care staff confirmed that rotas were sent on a monthly basis and if changes occurred due to staff leave or sickness, staff were contacted to be advised of the changes. Rotas showed and staff confirmed that they had been allocated sufficient travel time between visits. Staff expressed no concerns with how their rotas were managed or the time they had been allocated for visits. When we spoke with staff, they did not identify late calls as an issue and one staff member told us that previous timekeeping issues were resolved as they used their own car to travel.

The service was in the process of installing an electronic call monitoring system which at the time of the inspection had not yet been set up with all care staff. Once fully implemented, the care co-ordinator told us that they would be able to monitor in real time late or missed visits and follow up with staff if care visits had not been appropriately logged. However, we found that one care worker who had been set up on the electronic call monitoring had not logged into their visits for over three weeks which meant that we could not be assured that people had received their visits as scheduled. This had not been identified by management of the service. Despite the improvement measures identified, we found that staff were not deployed effectively and monitored to ensure that people received consistent care at all times.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care files contained risk assessments which addressed areas of risk such as medicines, falls, skin integrity, moving and handling, balance and mobility. Risk assessments detailed the risk and proposed solutions on how to mitigate or reduce risks. We discussed with the registered manager the importance of including individualised risk assessments for people with specific health conditions such as epilepsy and diabetes should they provide care for these people in the future.

Staff were able to describe what safeguarding and whistleblowing meant and the actions they would take if

they suspected people that they were supporting were subject to abuse. Comments from care staff included, "I have reported concerns. I reported to manager and had to follow up with a statement." All staff we spoke with told us they would report concerns to their line manager. However not all staff we spoke understood that there were external organisations they could report concerns to such as the local safeguarding authority, CQC or the police.

We looked at eight staff records in order to ensure that the service had undertaken safe recruitment checks for each person that it employed. Records confirmed that each staff member recruited had to undergo a number of checks which included a criminal records check (DBS), reference requests to check the staff members past performance in previous employments, identity checks and checks to confirm that the staff member was eligible to work in the UK. However, we noted that for two staff files there was only one reference on one staff file and on the second staff file there were no references on file. We spoke to the care co-ordinator who advised that they had received telephone confirmation of the person's previous employment history. However, they had not documented these checks. The registered manager and care co-ordinator told us that they would ensure references were documented and verified in the future.

Good

Is the service effective?

Our findings

We received mixed comments from people and relatives when we asked if staff were skilled to meet people's needs. Comments received from people included, "I would imagine they all have the right training to do the job" and "Yes the carers are good and most of the things with the service I am happy with." Comments from relatives included, "We are happy with the support. I think they really try and help out when they can" and "Yes very much so we could not cope without them." Staff told us that they had received appropriate training to enable them to carry out their role.

At the time of the inspection, the service was approaching their one year anniversary and all staff had been recruited within the last year. Therefore staff had not yet received an annual appraisal. The registered manager and care co-ordinator carried out regular spot checks and supervision sessions with staff and records confirmed this. Where actions and areas for improvement had been identified, the registered manager followed this up and actions were followed up at the next supervision session.

Staff told us that they underwent an induction and a period of shadowing experienced colleagues when they first commenced employment. The induction consisted of a one day training session which included medicines training, safeguarding adults, infection prevention and control, dementia awareness, moving and handling, equality and diversity, care planning and record-keeping. All staff were in the process of completing the Care Certificate. The Care Certificate is a training course that covers the minimum expected standards that care staff should hold in relation to the delivery of care and support.

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. The application procedures for this in community services are to be made to the Court of Protection. We checked whether the service was working within the principles of the MCA.

Care plans contained consent forms, which were signed by the people who used the service.

Staff knowledge of the MCA was mixed with some staff we spoke to not being familiar with MCA. However, all staff we spoke with understood the importance of obtaining consent from people prior to providing care or assistance. One staff member told us, "The majority of the clients have dementia at various stages. I always ask consent. We can't always tell. They have good and bad days. I never do anything without consent."

Support with nutrition and hydration was only provided if this was assessed as an identified need. Care staff were not involved in menu planning for people and were not always involved in monitoring people's nutrition and hydration as they would only be present at the person's home at certain times throughout the day for a specific time period. However, where staff supported people with meal preparation and support with eating, they documented what people had to eat and drink whilst they visited. Most people receiving care and support required only minimal assistance with meals which included preparing a ready meal or

assistance with making snacks and drinks.

Care records detailed peoples likes, dislikes and food preferences. One person's care plan stated that they liked pre-cooked meals and soup and tea and Weetabix for breakfast. Their care plan further stated that they required reassurance from staff to prevent them from eating the same soups all the time. Another care plan stated that the person liked teabags and a flask of hot water to be left beside their side table before care staff left.

People were only supported with their health and medical needs where this was required. Some people had family to assist when they needed to engage with health professionals. People's care plans listed details of health professionals such as GPs, social workers and also listed their current health conditions. Records confirmed that care staff documented concerns they had if someone was unwell and the actions taken by the service to ensure people received prompt professional treatment.

Good

Is the service caring?

Our findings

People and relatives we spoke with were complimentary about their carers. One person told us, "Yes very caring. When I am unwell I get a little upset and they will listen to me and try and help calm me down." Another person told us, "Yes they talk to me in a respectful way and are nice to me." A relative told us, "They seem like a nice group of people always caring and willing to help us out with whatever we need." Another relative told us, "We are happy with the support. I think they really try and help out when they can."

When we asked people and relatives if they had the same care staff, we received a mixed response. One person told us, "I have some regular ones that came around a lot and then there are new ones that I see as well." A second person told us. "It depends sometimes I have the same one coming around." A relative told us, "We have the same group of five or six carers that comes around." Staff told us that they provided care to a regular group of people and had established a relationship with them and their families. A staff member told us, "I work with five clients. The same people every day."

People and relatives told us that their dignity and privacy was respected. One person told us, "No complaints, well they will close the curtains before helping me change." Feedback from relatives in this regard included, "Yes they are respectful to all of us. They will not change her in front of us; they close the door when she is in the shower. Just little things like that" and "As far as I am aware they are. I have noticed when I am there they will close the doors when having a shower or getting changed things like that." Staff demonstrated an understanding of how to protect people's dignity and privacy and could give examples on ways they ensured this happened, for example, closing doors and curtains and covering exposed areas of skin.

People and relatives told us that staff from the service supported them to maintain their independence as much as possible. A person told us, "Yes without them I could not get everything done." Another person told us when asked if the received help to maintain their independence told us, "Yes they really do." A relative told us, "Yes, it is the little things they do that allow mum to be able to carry on with a normal life." Another relative told us, "Yes without them I don't think my dad would have much contact with the outside world."

Care plans addressed people's communication abilities and needs and provided guidance to staff on how to communicate with the person should they have a speech or hearing impairment.

The provider had an equality and diversity policy in place and records confirmed that staff had received training around equality and diversity. Staff confirmed that they adhered to people's preferred customs when entering their homes such as removing their shoes or wearing shoe covers, when necessary.

Requires Improvement

Is the service responsive?

Our findings

Care plans included background information and medical history about the person. Care plans were divided into sections such as home environment, communications, breathing, eating and drinking, mobilising, personal hygiene, skin and pressure care, social circumstances, pain, emotional health and medicines. These sections addressed people's assessed abilities in these areas and the level of support they required from care staff. One care plan stated that the person liked to walk slowly into their lounge and spend the day in their armchair. Another care plan stated that the person liked to talk about current affairs. Staff confirmed that they had read people's care plans and they could access them in people's homes.

People told us they were involved in the planning of their care. One person told us, "Yes they will ask me what I want and try and help." A relative told us, "Yes we sat down together and created a plan when we started using the services and I am usually kept up to date with what is happening."

Care staff recorded their daily interactions with people on daily recording sheets which were held at the person's home and returned to the office on a monthly basis for quality checking. We found entries made by care staff generally to be comprehensive, detailed and where concerns were noted such as people feeling unwell, they were recorded and escalated to management. However, we found instances of staff not making entries to record that they had visited the person. We discussed this with the registered manager who told us that where this had been identified, they had discussed with the care worker and where necessary taken disciplinary action which was confirmed during the inspection.

We looked at how the service handled complaints. People and relatives told us they knew how to make a complaint and would do so if needed. One person told us, "Yes there is a note in the folder that tells me." Another person told us, "I guess I would phone the office." We received feedback from people and relatives that they had submitted complaints regarding staff lateness. However they felt that their complaints did not result in a service improvement. One person told us, "I would phone and talk to the manager. I have made a complaint about the timekeeping but nothing has changed." One relative told us, "Yes, I would speak to the manager. I have spoken to them a few times now about the lateness. They seemed understanding but the carers are still late."

We looked at the complaints folder and saw that formal complaints had been logged, investigated and responded to. Complaints related to service issues such as late visits and medicines administration. Complaints were analysed and formed part of an improvement plan for the service which included medicines management and tackling late visits. This will be elaborated on further in the well-led section of the report.

The service requested feedback from people and records confirmed this. Feedback was requested from people, relatives and health and social care professionals on a quarterly basis. Feedback received from people and relatives was generally positive regarding care staff. Feedback received from people included the following comments, "Carers very kind and competent. Professional and person centred attitude. Very well done" and "Carers always helpful and always ask before they go if I need anything else. I always find my

carers cheerful. Carers are good and nice people." However, we found that many people and relatives raised punctuality of visits as an issue. Feedback was analysed and formed part of an improvement plan for the service which included improving on lateness. This will be elaborated on further in the well-led section of the report.

Requires Improvement

Is the service well-led?

Our findings

We received a mixed response from people and relatives about whether they felt the service was well-led. People and relatives generally praised the caring nature of staff. However, feedback was generally poor as a result of consistent late visits. Feedback received from people included, "They could do with more staff as they are usually always late", "I think they could do a little better with things like timekeeping", "I guess it is okay I have no real issues" and "Yes I think so. It is much better than the last service I used." A relative told us, "Yes, there are a few things that need to be changed and I think they are meant to be addressing them. Like how late the staff are."

Staff we spoke to were positive about working for the service and felt supported by management. One staff member told us, "They are very good. I know them so if I have any problems I can call. I am very happy." A second staff member told us, "They are always there when I need to speak to them. They always respond to me." A third staff member told us, "I have not had any problems. They are very accommodating."

The registered manager and responsible individual are registered nurses and during the inspection were knowledgeable around the specific health needs of the people who used the service and how to best support them. We saw evidence of prompt escalation of concerns regarding people's physical and mental health needs and involvement with multi-disciplinary meetings. Feedback recorded from a health and social care professional stated, "At Home Support Services [the provider] have been very pro-active in their support and have also gone out of their way to support a client in difficult times."

The registered manager had a number of systems in place which were used to monitor and improve the quality of the service provided. This included regular unannounced spot checks, audits of record keeping and medicines management, feedback surveys for people, relatives and health professionals and an oversight of staff training requirements. Although we found concerns regarding medicines management and late visits throughout the inspection, the registered manager told us they had identified these areas as areas for improvement and developed an improvement plan to address these issues.

An improvement plan had been developed and updated on a quarterly basis. The improvement plan was devised from feedback surveys, incidents and accidents, complaints and a local authority quality check. Identified areas for improvement included making care plans more person centred and increasing family involvement, implementing electronic care monitoring to reduce lateness, implementing individual medicines supervisions, additional medicines training and providing dementia training to staff. Where actions had been completed, the action plan had been updated. Although issues were picked up and an improvement plans was in place, improvements had not been made in all areas. People and relatives felt that improvements had not taken place.

The provider had also identified their main challenges as a provider and set actions to address these which included managing capacity when there are short notice staff cancellations to reduce customer dis-satisfaction and staff development to meet the standards for the care certificate.

Staff meetings took place but at the time of inspection, only management meetings were recorded and actions identified. The registered manager told us that due to distance between the office and where staff worked, they would arrange a staff meeting at a central venue, however, the meetings were not documented. The registered manager and care co-ordinator advised us that moving forward, they would ensure staff meetings were appropriately documented.

Throughout the inspection we gave feedback to the registered manager, responsible individual and care co-ordinator and clarification was sought where necessary, for example in relation to the concerns regarding medicines management and timing of care visits. The management team demonstrated a willingness to learn and reflect in order to improve the service people received as a result.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)(2)(g) Medicines were not always managed safely and effectively.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) The service did not always ensure staff were deployed effectively to ensure people received their care on time.