

Knowles Home Care Limited

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on the 22 February 2016 and was announced. The provider was given 48 hours' notice because the location provides domiciliary care and we needed to be sure that someone would be at the office.

Knowles Homecare Ltd is a domiciliary care service providing care and support to people living in their own homes. The office is based in the city of Leicester and the service currently provides care and support to people living in Leicester and Leicestershire. At the time of our inspection there were 14 people receiving personal care from the registered provider.

Knowles Homecare Ltd had a registered manager in post who was also the registered provider. 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 found the registered provider had breached the regulation about medicines. This was because medicine records did not support the safe management of medicines. In particular, the registered provider did not retain up to date information about people's medicines and could not provide any evidence of audits of medicine records.

You can see what action we have asked the registered provider to take at the back of the full version of this report.

People using the service and their relatives told us that they felt safe. Staff had a good understanding of safeguarding including how to report concerns. Staff told us they felt that concerns would be dealt with thoroughly by the registered provider.

Potential risks had been assessed, such as risks associated with the person's care and support and their living environment. Risk assessments did not always record the measures in place to control the potential risks.

People were cared for by reliable and appropriately recruited staff. People who used the service told us that staff stayed the time and often stayed longer if needed. Staff members told us they had the time they needed to care for people.

People were cared for by knowledgeable and competent staff though the registered provider was unable to show us evidence of essential staff training. Staff felt they were well supported by the area manager on a day to day basis.

The registered provider followed the principles of the Mental Capacity Act 2005 (MCA). People were asked for permission and consent before receiving care and staff respected their right to refuse.

People using the service had care plans which were person-centred, detailed their likes, preferences and needs. People told us that they had been involved in developing care plans following an assessment of their needs and we saw evidence that people had signed consent to care where possible. However, Care plans were not always reviewed in a timely manner and the registered provider did not retain records of care review meetings. This meant that people's care plans may not reflect people's current or changing needs and did not show how people had been involved in the review of their care.

People knew how to complain and felt they were listened to if they had any concerns.

People and their relatives were positive about the management of the service and found the service to be warm and approachable with an 'open-door' culture. The area manager was well known by all staff and people using the service but some people were not aware of the registered manager who was also the registered provider.

A quality assurance process was in place but had been applied informally with little recorded evidence of outcomes. Checks and audits were fragmented and recent audits had not been completed. People's views had been sought through six monthly consultation surveys and positive feedback had been given during the most recent consultation. These showed people were satisfied with their care with no areas of concern or areas for improvement identified. We found no evidence that quality assurance checks and feedback was used to promote learning or continuous improvement of the service.

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 records did not always support the safe management of medicines.

Risks assessments did not always record the measures in place to control the potential risks.

People were cared for by reliable staff who said they had the time to care for people.

There were sufficient numbers of staff to meet people's needs

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

People using the service told us that they felt they were supported by skilled and competent staff. However, the provider did not retain any records to show that staff training was up to date.

Staff felt they had access to informal support and guidance but did not receive regular supervision.

People were asked for permission before receiving care and staff respected their right to refuse.

Is the service caring?

Good ●

The service was caring.

People were happy with care they received from the service.

People were supported by staff who they considered to be warm and caring in their approach.

People received care and support from a consistent group of staff that understood their individual needs.

Is the service responsive?

Requires Improvement ●

The service was not consistently responsive.

People's needs were assessed before receiving a service. People had been involved in developing their care plans.

Staff provided the care and support that was personalised, which took into account people's preferences and individual needs.

People knew how to raise a complaint and felt that their concerns were listened to and acted upon.

Is the service well-led?

The service was not consistently well-led.

People were satisfied with how the service was managed.

The provider did not have robust quality assurance systems in place to check the quality and safety of the service

People using the service and their relatives were provided with opportunities to share their views and opinions on the service through recent consultation.

Requires Improvement 

Knowles Home 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.'

This inspection took place on 22 February 2016 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 one inspector.

We reviewed the information we held about the service. We looked at 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. We also looked at other information sent to us by people who used the service, relatives of people who used the service and health and social care professionals.

During our visit we spoke with the registered manager who is also the registered provider and the area manager. We also spoke with five people who used the service and their relatives, three staff members and the office administrator/co-ordinator,

We reviewed six people's care records which included their care plans, risk assessments and daily records to see how their care and support was planned and delivered. We also looked at the recruitment files of three members of staff, key policies and procedures, complaints and incidents, records of meetings, call schedules and information relating to quality assurance.

The service provided us with a list of people who used the service so we could select people we wished to

Speak with and arrange convenient times to speak with them.

Is the service safe?

Our findings

People using the service and their relatives told us that they felt safe. One person told us "my carers make me feel safe because they know what they are doing when they are helping me." A relative of a person using the service told us that they had no concerns with carers keeping their family member safe as their family member had never had any accidents or marks on them as a result of carers support.

Staff were able to describe how they kept people safe. One care worker told us that they always checked with the person if they felt safe and looked for any hazards that may put the person at risk whilst they were supporting them and before they completed the visit. Another staff member gave an example where they noticed the stitching on a person's hoist sling was coming undone and immediately reported this to the person's family members as presenting a possible risk to the person during assisted transfers.

People we spoke with managed and administered their own medicines, some with support from their relatives, whilst others needed support from the care staff. One person told us that they managed their own medicines which were dispensed in a dosset box but were supported by care staff to take any prn (as required medicines) or anti-biotics.

We saw that the registered provider has assessed the level and nature of support each person using the service needed to manage their medicines. People had signed consent to receiving support with the medicines where they were able to. Staff recorded support with medicines in the person's daily log. However medicine records did not support the safe management of medicines. We saw that the service did not keep an up to date record of people's current prescribed medicines. We spoke with one person who used the service who told us that staff periodically supported them to manage medicines which were prn and not dispensed in a dosset box. We saw that this information had not been updated in the person's care records. There was no evidence that medicine records had been audited on a regular basis to ensure that records were accurate and completed correctly.

Staff informed us that they had received training in the safe management and administration of medicines. The registered provider was unable to provide us with any evidence of training for staff. This meant that people could not be assured that staff had the knowledge and information they needed to support the person to manage their medicines safely.

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

Staff had a good understanding of safeguarding and knew how to report concerns. Staff were able to describe how they would respond to incidents where they suspected a person was being abused and told us how they would report concerns to the registered provider straight away. Staff told us that they had an awareness of whistleblowing and were confident to report concerns about poor or unsafe practices which could put people using the service at risk. Not all staff who we spoke with were aware of how to contact external agencies if they felt someone continued to be at risk or the registered provider was unavailable

We looked at the provider's safeguarding and whistleblowing policies and saw that they did not include local safeguarding guidance or contact details for relevant external agencies. We raised this with the provider who told us they would review and update the policies to include this information and make available to all staff.

Staff told us that they had attended safeguarding training. However we were unable to verify this as staff training certificates were not held on staff training files and the provider had not maintained an up to date training matrix. The provider informed us that they were in the process of updating the training matrix and would identify if anyone needed refresher training in safeguarding.

The registered provider and area manager carried out a range of assessments to determine whether people were at risk. These included risks associated with the person's care and support, as well as their living environment. Risks assessments also included standard assessments such as mobility and falls assessment as well as identifying any potential risks posed by people's medical conditions. For example, one person became confused at times due to their medical condition. Although risk assessments identified potential risks to people's safety, risk assessments did not always record the measures in place to control these risks. For instance, one person was assessed as being at an increased risk of developing pressure sores. However, their risk assessment only provided information about the action staff should take to respond to changes in the condition of the person's skin but did not detail the action required to prevent the person from developing pressure sores in the first place.

We looked at samples of the call schedules which are developed using an electronic system. We saw that there were sufficient numbers of staff to meet people's needs and help to keep them safe. Staff told us that they felt they had enough time to meet people's needs during their visits.

Recruitment procedures were in place to ensure that only suitable staff were employed. However, we saw that one staff member's recruitment file did not show that references from previous employers had been obtained as part of the recruitment procedure. We raised this with the registered provider who told us that they would ensure that they located the missing information and recorded it on the staff member's recruitment file. Checks had been made with the Disclosure and Barring Service (DBS) before employing new staff. The DBS checks helps employers to make safer recruitment decisions and prevent unsuitable people from working with people using the service.

The registered provider had a system for logging and investigating incidents and accidents, although there were no accidents or incidents recorded on file at the time of our inspection.

Is the service effective?

Our findings

People who used the service and relatives told us they found care staff knew how to support them effectively. One person told us "They know how to move me safely and understand how to support me." A relative of a person using the service told us that the carers followed the care plan and were able to communicate effectively with their family member.

Staff told us that they had attended a lot of training but had not attended any training in the last six months and felt some of their training needed updating. Staff confirmed that they had undertaken induction which involved a day with the registered provider learning about the role and opportunities to shadow more experienced staff before undertaking visits on their own. This meant that new staff had the opportunity to be introduced to people using the service prior to undertaking visits on their own. Staff also told us about training they had undertaken in the last two years which included food hygiene, manual handling and hoist training, supporting people to meet nutritional needs and medicine awareness. Staff felt that the training gave them the skills and knowledge to be able to support people effectively.

We found the staff training records were not reflective of what the care staff had told us. The registered provider was unable to show us any evidence of induction for staff or training certificates. This meant that the provider was unable to identify if staff had the required training and knowledge to support people effectively. The registered provider explained that they were reviewing the training matrix and meeting with individual staff to identify refresher training that required updating. The registered provider told us they would use this information to bring the training matrix up to date and evidence training undertaken by staff.

Most care staff told us they felt supported by the area manager. They told us that the area manager often called in to see them to check everything was ok and they felt they could either speak to them directly or call them to discuss their work or any concerns as and when required. Some staff had not received formal supervision for many months and felt that they had been left to get on with things for some time. Care staff did not receive regular supervision or staff meetings. All care staff received a weekly rota and communication from the office if there were changes to a care package. The area manager explained that they tended to use training sessions as an opportunity to have staff meetings but no notes were taken of these meetings. This meant that care staff had little opportunity to receive information or make suggestions which could affect people using the service.

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. Where 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. The registered provider's policies and procedures for the MCA and Deprivation of Liberty Safeguards (DoLS) were up to date. Staff understood the importance of enabling

people to make their own decisions. A relative of a person who used the service told us that staff used non-verbal communication to enable their family to make day to day choices such as what they wanted to wear and when they wanted to do things.

People told us they made decisions about their plan of care. People's plans of care showed that the principles of MCA had been used when people's ability to make decisions had been assessed. We found that people or their appointed representatives had signed consent forms in their plans of care.

Staff told us they would always ask people for permission before providing care. They went on to say they would respect a person's decision including their right to decline. Staff said if someone declined they would check with the person that they were sure, document the decision and notify the office. Staff understood that sometimes there can be conflict as a result of someone's choice but felt that they should respect the choice and inform the area manager if they had concerns about a person's health and welfare as a result of their choice.

Some people using the service received support to prepare their meals. One person told us that care staff always consulted them to make sure that their meals were to their liking. A relative spoke positively about how care staff supported their family with their meals. We looked at the Information about people's dietary requirements and preferences recorded in their plans of care. We saw that some people who required support to meet their nutritional needs had detailed information recorded in their plans of care but other people's plans of care contained very little information. This meant that some people might be at risk of not having their nutritional needs met effectively.

Most people using the service were able to manage their own health care needs or relatives supported them with this. One person using the service told us that care staff supported them to access emergency medical assistance and waited with them until it arrived. Another person told us that they communicated routine medical appointments to the office and this in turn was communicated to care staff and the care plan updated as appropriate. This meant that staff were kept informed and had the knowledge to effectively support people to meet their health needs.

Is the service caring?

Our findings

People were cared for by reliable staff who had the time they needed to care for people. People told us that they were happy with the care they received from the service. One person told us "They [care staff] don't time watch and will go out of their way for me on occasions." A relative of a person using the service told us "The care staff are not just task orientated, they are warm and caring." Relatives told us care staff supported them as well as their relative. One relative told us "They [care staff] are a good support for us and work with us to help us to care for our family member." Another relative told us that they always knew which carers were coming and all carers were reliable and professional.

People and their relatives described to us warm and positive relationships between people and care staff. One relative told us that they could regularly hear laughter and banter between their family member and care staff which showed the warmth between them. Another person who used the service told us "It's easy for me to feel down because of my health. My carers are good at knowing when I am down and they distract me to lift my mood."

People were cared for by staff who knew them well. One person told us "I have consistent carers so I always know who is coming. This helps care staff to learn about me and my needs." One staff member told us that they always went with an experienced carer to be introduced to clients and get to know them before taking on visits. There was information within care plans to help guide staff about appropriate strategies to follow to maintain a person's well-being. For example, for one person staff were advised to keep communication to a minimum until they were fully awake. For another person, staff needed to be aware that the person felt low or tired on some days.

People were supported to be as independent as possible. One person said "I make the decisions about my care and care staff respect my decisions and choices." Another relative told us that care staff supported their family member to make day to day decisions and choices. Staff described how they prompted people's independence through encouraging people and supporting them. One staff member told us that they let people do as much for themselves as they could and respected their choice to do this, even if the person found it difficult.

Most people felt that they were treated with dignity and respect. One person told us that they felt care staff were very conscientious and always treated them with respect. A relative told us that they felt their family member was always treated with dignity and respect, particularly whilst care staff were supporting them with personal care. Staff who we spoke with were able to demonstrate that they understood the importance of treating people with dignity and respect. They were able to describe how they would keep people covered up as much as possible when supporting people with their personal care needs and asked them what they wanted to do for themselves.

One relative felt that staff did not always treat their family member with respect. For example, they told us that care staff often spoke in their first language to each other or on their mobile telephones in front of their family member. They told us that their family member was not able to understand what they were saying

and they felt this was disrespectful. They also felt that some care staff did not respect their family member's dignity and right to privacy whilst they were supporting them with personal care. They told us they had raised this as a concern with the area manager who had spoken with staff but there had been little improvement.

People were provided with information when they first started to receive a service. This included a contract of care and service user guide which detailed the range of services the registered provider offered and contact arrangements.

Is the service responsive?

Our findings

People told us that the service was responsive to their needs. One relative told us "the flexibility of the service is fantastic. The service is quick to respond if we need to change the times of calls or have extra calls." A person who used the service told us "my carers are there when I want them and help me how I want them to,"

People told us that their care needs had been discussed and agreed with them when the service started and their needs and preferences were being met. People had access to their care records in their own homes so they could read them at any time. People told us that staff spoke with them about their care and records showed that people and/or their relatives had signed to confirm they had discussed their care with staff and agreed to the care planned. One person who used the service told us "I was involved in all aspects of my care plan and I know that staff are very aware of it. There is nothing that they don't know when they are helping me." A relative of a person who used the service confirmed that they had been involved in the development of their family member's care plan and had a copy of the plan for reference if they needed it.

Care records contained information about people's background, such as their next of kin, religion and their medical contacts. Care plans also provided care staff with information about the person, such as their preferred term of address, key events and experiences in their life history, hobbies and interests and their communication needs. People's needs had been assessed to identify the support they needed across a range of needs, such as personal care and diet. Care records clearly identified people's preferences, such as food and drink and likes and dislikes. We discussed with the registered provider that there was little detailed information for people who had very specific communication needs. For example, assessments did not detail key signs and symbols that the person used to communicate or take into account the environment or how staff could best communicate with someone who had a hearing impairment. The registered provider acknowledged this and told us this would be incorporated into care plans to provide staff with detailed guidance.

The information gathered during the initial assessment was used to develop people's care plans. These were structured around providing guidance through 'daily routine' records for staff to follow to promote consistent support. For example, one care plan stated the order in which the person liked the support to be provided to them. Care staff told us that they looked at the care plans to get to know about the person, not just how best to support them.

Care records we looked at did not show people's care needs were reviewed regularly. The registered provider told us that there was a system to review care plans to make sure they accurately reflected how people needed to be supported. They told us that they did not keep notes of any review meetings but in the event of any changes to the care provided, a new care plan was developed which replaced the existing plan. However people who used the service and their relatives told us they had not had any review of their care plan for sometime. Some people told us their care needs had not changed and they used an informal system where they could contact the area manager if they needed to make any changes. Other people told us that they found the lack of formal, regular reviews frustrating as they felt that the service was slow to

respond to requests for minor changes to the care plan. The registered provider acknowledged that some care reviews were overdue and told us they would arrange reviews as soon as possible.

People using the service and their family member's knew how to complain. They told us they had been made aware of the registered provider's complaints procedure and provided with contact details. A relative told us that they knew they could contact the area manager quickly if they had any concerns or wanted to make a complaint.

There were no written complaints on file but where people had made verbal complaints, these were recorded in people's individual care records. We saw that although details of the complaint were recorded together with outcomes, records did not always show actions taken to address lessons learned to make sure they did not happen again. Complaint records were kept with people's care plans which meant that the registered provider was not able to identify any potential trends or patterns in complaints. We discussed this with the registered provider who told us they would begin to retain a central file of complaints to address this.

We looked at the registered provider's complaints procedures and saw that it was up to date but did not include the contact details for the Local Authority Ombudsman, Care Quality Commission or advocacy details should someone need support to make a complaint. We raised this with the registered provider who told us they would update the policy and procedure and ensure people were provided with up to date information.

Is the service well-led?

Our findings

People who used the service and their relatives told us that they felt the service was well-managed. One person told us "It is very good compared to some agencies I have used in the past." A relative told us "It is a well-led service. The contact is brilliant and communication is quick and efficient." Another relative told us that there was an "open-door" culture where they could contact the area manager at any time.

Some of the people who used the service did not know who the registered manager was. One relative told us "I have never spoken to them and wouldn't know how to get hold of them. I always speak with the area manager." The service had a registered manager in post who was also the registered provider. The registered provider had been absent from the service for some months but had remained in contact with the area manager who had taken on day to day responsibility in the interim period. They told us they were now able to return to a more active role within the service.

Staff told us that they felt supported by the area manager who frequently attended calls with them and was in regular contact either in person or by telephone. This meant that staff were provided with regular informal opportunities to feedback about people's care. We saw that the registered provider had not held regular staff meetings which meant that staff did not have the opportunity to share information or discuss important issues as a group. The registered provider was aware of this and told us that they intended to arrange a staff meeting in the very near future.

The registered provider had a quality assurance system in place but this was informal and fragmented. The area manager carried out six monthly spot checks on staff work practices and regularly undertook visits to people's homes' as part of their role to evaluate the quality of care people received. However, the outcome of visits were not recorded and the registered provider could not show us evidence that any visits had been undertaken in recent months.

The registered provider did not carry out any structured audits of people's care records and staff records. For example, we saw that staff entries in people's daily logs varied in terms of the quality of recordings. The area manager did check entries periodically when they collated information for archive but there was no recorded evidence of this process.

People using the service and their relatives were sent an assessment form every six months to feedback about the staff providing their care and the performance of the service. They were asked to comment and rate care staff on areas including their punctuality, professionalism, communication and quality of care received. They were also asked to evaluate if the service had improved, stayed the same or deteriorated. We viewed a selection of responses to this consultation. All responses showed that people were satisfied with their care with no areas of concern or areas of improvement identified. The registered provider told us this feedback was noted but was not collated to identify any trends and patterns. This meant that the registered provider could not use the information to continuously improve the service.

The registered provider was able to discuss proposed development of the service and short and long-term

business objectives. This included contingency planning and improving the quality of the service provision.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>People who use the services and others were not protected against the risks associated with unsafe or unsuitable care and treatment because records and systems operated by the registered provider did not support the safe management of medicines</p> <p>Regulation 12 (2) (g)</p>