

Care at Home Services (South East) Limited

Care at Home Services

(South East) Ltd -

Canterbury, Herne Bay &

Whitstable

Inspection report

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19 May 2023

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Care at Home Services (South East) Ltd - Canterbury, Herne Bay & Whitstable is a domiciliary care agency providing care and support to a wide range of people including, older people, people living with dementia, and people with physical disabilities. At the time of our inspection there were 101 people using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found

Checks and audits to monitor the quality and safety of the service provided were not consistently robust. Whilst surveys were used to monitor the quality of service, the results had not always been analysed and provided to the registered manager by head office.

Risks to people's health, safety and welfare and care plans were not consistently detailed. Medicines recording was not consistently accurate. For example, body maps, for prescribed creams, were not used in line with best practice.

People were protected from the risks of abuse by staff who understood how to recognise signs and where to report concerns to. People were protected from the risks of infections by staff who followed safe infection control practices.

People were supported by a regular staff team who knew people well. People and relatives told us staff generally arrived on time and stayed the correct length of time. Staff had been recruited safely.

People felt the service they received was good and told us they felt involved in the planning and management of their care and support. People told us the staff were kind and caring and respected their privacy.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was good (published 1 January 2018).

Why we inspected

This inspection was prompted by a review of the information we held about this service.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Care at Home Services (South East) Ltd - Canterbury, Herne Bay & Whitstable on our website at www.cqc.org.uk.

Enforcement

At this inspection we have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this report. We have identified a breach in relation to good governance at this inspection.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Care at Home Services (South East) Ltd - Canterbury, Herne Bay & Whitstable

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team

The inspection was carried out by an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own homes.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 11 May 2023 and ended on 19 May 2023. We visited the location's office on 11 May 2023.

What we did before the inspection

We reviewed information we had received from the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with 12 people and a relative about their experience of the care provided. We spoke with 9 staff, including care staff, co-ordinators, the registered manager, and the head of community operations. We reviewed a range of records. This included 5 people's care records and associated risk assessments and multiple medication records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies, audits and training records were also reviewed.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risk to people's health, safety and welfare were assessed, monitored and reviewed. However, some risk assessments lacked detail. For example, when people had a catheter to drain urine from their bladder, there was no information to alert staff to possible signs of infection or the catheter bypassing (not working as it should). Staff were able to tell us about the signs they would look for to ensure people were safe and the registered manager began to take action during the inspection to update the risk assessments.
- Care plans lacked detail about individual health conditions. For example, signs that could indicate a decline in health. We discussed this with the registered manager who arranged for care plans to be updated. This was an area for improvement.
- People's home environments were assessed and considered people's health conditions and any specialist equipment used.
- Other risks to people were assessed. There was guidance about how to reduce risks. For example, there was guidance for staff to follow about how to move people safely. When people had a lifeline alarm, to help them stay safe and independent, staff made sure these were worn before they finished each care call.

Using medicines safely

- Medicines recording was not consistently accurate. For example, when people were prescribed pain patches, staff did not always record where the patches had been removed from and where they had been replaced. Body maps were not used in line with best practice. Following the inspection, the head of community operations confirmed this had been rectified on the electronic system.
- When people needed medicines on an 'as and when' basis (PRN), there were no PRN protocols in place. Staff did not follow the provider's PRN policy. Care at Home provided a process to follow, and this had not been followed. CQC were told there were issues with the electronic system and the head of community operations raised this concern with head office during the inspection. This was an area for improvement.
- People received their medicines as prescribed. People told us they had their medicines on time and were supported with the application of prescribed creams.
- Staff completed regular medicines management training and their competency was assessed to ensure they followed best practice when administering medicines.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risks of abuse, harm and discrimination by staff who were trained to recognise the potential signs of abuse. A member of staff commented, "If I have any safeguarding concerns, I contact the office straight away and I document my concerns in the daily log." Staff understood who they could raise concerns with, outside the organisation, should they need to.

- The registered manager and staff knew how and when to raise concerns to the local authority safeguarding team and Care Quality Commission.
- People felt safe being supported by staff. A person said, "I feel safe with them, they make me feel comfortable, everything is good all round. I feel fine with [carers using] the hoist. They are all trained up."

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 MCA 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 Mental Capacity Act (MCA). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

- At the time of the inspection there was nobody with a Court of Protection order in place.
- People told us staff gained their consent before providing care and support. One person said, "They [staff] always ask for my consent before supporting me."
- Staff understood, when a person was not able to make complex decisions themselves, that discussions were needed with the relevant people, such as relatives and health care professionals, to ensure decisions were made in people's best interests.

Staffing and recruitment

- People were supported by a regular team of care staff. People told us staff generally arrived on time and they were informed in their call was running late. They said, "I mostly have the same carers. I didn't want male carers and my request has been kept" and, "I have mostly the same team of carers and one main carer. Anyone who fills in has been brilliant."
- Staff told us they had enough time scheduled to travel to each call. They said if they had any concerns, they would contact the office team to discuss it. The registered manager monitored the timeliness of care calls.
- People were supported by staff who had been safely recruited. A full employment history was requested, and gaps in employment were explored and recorded. References were obtained and Disclosure and Barring Service (DBS) checks were completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

- People were protected from the risks of infections by staff who followed safe infection control practices.
- Staff completed training about infection prevention and control. Staff told us they wore personal protective equipment, such as gloves and aprons. They told us they had plenty of stock available when they needed it.
- The registered manager ensured staff kept up to date with current Government guidance.

Learning lessons when things go wrong

- Accidents and incidents were recorded. These were reviewed by the registered manager to ensure any patterns were identified and relevant health care professionals could be contacted if needed.
- Staff recognised incidents and reported them appropriately.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Checks and audits were not consistently robust. Some of the shortfalls found during the inspection had not been identified by the registered manager and management team.
- Staff surveys had been completed in November 2022. However, the provider's head office had not provided analysis of the responses to the registered manager to allow them the opportunity to celebrate areas of strength or address any shortfalls. The registered manager chased this during the inspection and was provided with basic information from the 13 staff who had responded. This was an area for improvement.
- The process to assess staff competency was not consistently robust. The quality of the assessments varied. We discussed this with the registered manager. Following the inspection, the registered manager provided a new set of documents to help ensure the approach to competency assessing was more consistent.
- Staff refresher training was not up to date. The registered manager had recognised this and was taking action address this. However, staff we spoke with were knowledgeable about the people they supported and how to support them safely. Following the inspection, the registered manager confirmed most staff training had been updated.

The provider failed to ensure systems and processes were established and operated effectively. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People told us they felt involved in their care and the support they received was good. People said, "They are respectful and kind, they care about what they are doing" and "I feel involved with my care. I had a review last month. I read and signed their care plan."
- People completed quality surveys to provide feedback about their support. Analysis of these had been provided by head office and reviewed by the registered manager to check for any areas for improvement. Where concerns had been identified, action had been taken to address these.
- Staff told us they felt valued by the service. Regular staff meetings were held and staff had the opportunity to discuss any ideas to improve the service provided. One to one supervision meetings were held and performance and personal development were discussed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People and their relatives told us they felt the service was well-led and they would recommend it to others. A person said, "I think it's well managed. [The registered manager] is definitely approachable and listens to what you have to say."
- People told us staff were kind, caring and knew them well. A person said, "[Staff] have got to know me well. I am always pleased to see them. They will sit and have a chat for five minutes; it breaks the day up."
- People's independence was promoted by the staff team and people were encouraged to do as much for themselves as they were able to do. A person said, "They are very good with dignity and respect, and they encourage my independence."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

- The registered manager worked in partnership with others and understood their responsibilities to be open and transparent in accordance with duty of candour guidelines. This is a specific set of legal requirements that services must follow when things go wrong with care and treatment.
- Notifications of reportable incidents, such as a death, had been submitted to the Care Quality Commission in line with guidance.
- The registered manager and staff were working closely with the local authority and people's health care professionals to continue to drive improvements with the quality and safety of the service. Referrals were completed when needed. This helped make sure people received additional support when they needed it. Staff followed any advice given.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and processes were established and operated effectively.