247 Home Care Ltd

247 Home Care Ltd

Inspection report

Regus House, Windmill Hill Business Park
Whitehill Way
Swindon
SN5 6QR

Tel: 01793441808
Website: www.247homecare.org

Date of inspection visit:
31 October 2022
02 November 2022

Date of publication:
23 January 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
247 Home Care Ltd is a domiciliary care agency providing personal care to people in their own homes. The agency also has a local authority contract to support people being discharged from hospital. At the time of our inspection there were 45 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
Risks people faced were not always identified or assessed, which did not ensure safety. Action was not always taken to minimise such risks. Records did not always show a robust recruitment procedure, and scheduling of people's visits was challenging. This was because there were not always enough staff to consistently provide cover, particularly at weekends or at times of staff sickness. Records did not show people's medicines were always managed safely. People felt safe with staff supporting them, but systems to help protect people from the risk of abuse were not always effective. Systems were in place to ensure good infection prevention and control practice.

People had an electronic care plan in place. However, some of the information, including the impact of people's health conditions was limited. This did not ensure staff had the required information to support people in the best possible way. Staff had not always documented an account of the visit, and some terminology used was not respectful or demonstrated a lack of understanding of people's needs. People were generally happy with the support they received and were enabled to be part of their community, as part of their care package if needed. People and their relatives knew how to raise a concern or a formal complaint. They felt they would be listened to, and action would be taken to resolve their concern.

There was a quality auditing system in place, but it was not always effective, as shortfalls were not consistently being identified or addressed. This included those areas identified in this inspection such as risk management, the safe administration of people's medicines, recruitment procedures, care planning and staff training. The provider did not have a deputy or care manager so was finding both roles of registered manager and provider, a challenge. They also completed people's support which took them away from their management responsibilities. This had impacted on their management oversight and the quality of the service. People and their relatives were encouraged to give their views about the service and a positive culture was promoted.

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 31 December 2019)

Why we inspected
The inspection was prompted in part due to two separate concerns received about staff recruitment and training, missed and inconsistent timing of people's visits and care planning not being undertaken in a timely manner. A decision was made for us to inspect and examine those risks.

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

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 247 Home Care Ltd on our website at www.cqc.org.uk.

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

247 Home Care Ltd

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 undertaken by one inspector, an assistant 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 houses and flats.

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 the provider was registered as the registered manager.

Notice of inspection
This inspection was announced.

We gave the service notice on the day of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 31 October 2022 and ended on 7 December 2022. We visited the location's

office on 31 October 2022 and 2 November 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with 6 people who used the service, 10 relatives, 7 staff including the registered manager/provider and 1 health and social care professional. We looked at care planning documentation and associated risk assessments, medicine administration records and information related to the management of the service.

Requires Improvement

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; Learning lessons when things go wrong

- Not all risks people faced had been identified, assessed or mitigated, which did not promote safety.
- Some people had been assessed as being at high risk of pressure damage, yet they did not have a plan of care in place to ensure healthy skin. This meant they were at increased risk of their skin integrity deteriorating.
- Risk management guidance was not always available, and some risks had not been assessed. For example, one care plan identified the person needed monitoring at all times due to the risk of choking, but there was no further detail such as the foods they found more difficult to chew or how they needed their food presented. Another person had bed rails in situ, but an assessment identifying possible risks such as entrapment had not been completed.
- Whilst some people told us staff arrived to support them on time, this was not the case for all. There had also been some missed visits, including four in October 2022. Whilst relatives had undertaken people's support, so the impact was low, this did not ensure a reliable service. One person told us, "It's all the time that they seem to scrabble to get here." A relative told us, "Sometimes they turned up and sometimes they didn't. It was hit and miss. If they didn't come at all, it was because they didn't have anyone to cover, and they usually phoned to tell me."
- Some people needed two staff to assist them with their support due to safety whilst using the hoist. Staff confirmed this but said there were times when one staff member undertook the visit. This placed people at increased risk of avoidable harm. One person told us being supported by only one member of staff happened to them. A relative told us, "The second carer never arrives on time. In the morning, they are supposed to arrive at 8am, but the agency changed it to 8.30 am, without telling me. This means they often come at 8.45 am, by which time the other carer has almost finished, working on their own." After the inspection, the provider told us they had addressed this by allocating two staff to work together for all such visits throughout the day." This ensured two staff would be available to provide support as detailed in the person's care plan.
- A record of accidents and incidents was maintained. This included a report about one person who fell from a hoist whilst staff were supporting them. Whilst the provider told us this was reported to the local safeguarding team, documentation regarding this was not available. The provider was not able to provide documentation of any investigation or action taken to understand what had happened and why, to help prevent a recurrence. Two other people told us staff competence and confidence whilst assisting them to use their hoist, did not make them feel comfortable or safe. One person said, "A lot of staff don't know how to use the hoist. I have to show them. They'll say they've had manual handling training, but that they haven't seen this type before."

Systems were not in place to identify, assess and mitigate risks to people's safety. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people were positive about the timings of their visits. This included, "Usually they're on time, occasionally they're a little bit late," "They usually arrive within 10 minutes of the time" and "They're never late, but if they are, they're very apologetic."

Staffing and recruitment
● There were staff shortages and people's care visits were not always easily covered. This was particularly so at weekends and at times of staff sickness and annual leave, and meant staff were late supporting some people. There had also been some missed visits with a reliance on family members to provide their relatives care.
● On the morning of the first day of the inspection, there were 10 care visits for that day, documented on the white board in the office. These had not been allocated to a member of staff. Staff told us whilst the visits were covered, they spent much of their time each day trying to arrange cover for people's visits.
● Staff told us some care packages were being accepted in geographical areas, which were not covered by a core group of staff. This made allocating staff to these people difficult and had resulted in late care visits. The provider told us they used another agency to cover people's visits if they could not be covered by their own staff.
● The provider told us recruitment was ongoing, and they were reviewing the scheduling of people's visits to ensure better efficiency. This said this was beginning to make a positive difference to time keeping.

● People and their relatives told us the agency was short staffed. One person told us, "I wish they weren't so short staffed. A lot of staff seem to let them down at the last minute, especially the youngsters. At the weekends and holiday time, they can't get the cover, and that's the root of the problem."
● Records did not show staff were robustly recruited. This was because applications did not always show a full work history of the candidate or their reason for leaving their previous position. As part of one application, the provider had requested information about the candidate's previous work performance from two different sources, but only one was returned. This did not comply with the provider's recruitment policy and gave limited information about the applicant. Another applicant had not been checked against their photograph, which was a requirement from the Home Office.

We recommend the provider reviews their recruitment processes to ensure all staff are safely recruited.

Using medicines safely
● People's medicines were not always safely administered.
● Staff had not always signed the medicine administration records (MAR) to show they had administered people's medicines. This included 18 gaps in the signing of one person's blood thinning medication in the month of October 2022. This meant the provider could not be assured people were receiving their medicines as prescribed. The electronic system had raised alerts to enable immediate action to be taken, but a record of this was not in place.
● Within the daily records, staff had documented they applied topical creams to a person's skin. However, the cream was not identified on the (MAR). There was also no clarification such as the name of the cream, the reason for its prescription, where it was to be applied or with what frequency.
● Some people had medicines that were to be administered 'as required'. There was no guidance for staff to administer these medicines as prescribed, or to ensure maximum effectiveness.
● Not all staff had received refresher training in the safe administration of medicines despite this being deemed mandatory by the provider. Staff had also not had their competency assessed to show they were

able to safely administer people's medicines.
● People had been prescribed blood thinning medication, which meant they were at risk of heavy bleeding if they sustained an accident. This was not identified within care planning information, which did not promote safety.
● Audits showed a list of alerts which had been raised when staff had not signed the MAR. The audits did not cover any other checks such as the correct instructions on the MAR or the timing of those medicines which were time specific.

Systems had not been effectively established to ensure the safe administration of people's medicines. This placed people at increased risk of avoidable harm. This was a breach of regulation 12 of the Health and Social Care Act 2008.

Systems and processes to safeguard people from the risk of abuse
● Systems to help protect people from the risk of abuse were not always effective.
● There had been two separate incidents of theft of people's monies, which were being investigated by the police. There had been some learning following this, including discussions with staff and additional training. The provider told us they were much more aware of not being so accepting of trust and believing what they were being told.
● Following the incidents, the provider told us they had reviewed the systems in place regarding the handling of people's monies. This included regular monitoring and making sure there were clear records and receipts to demonstrate expenditure.
● Staff told us they had received safeguarding training, but records showed such training was out of date for many.
● Staff told us about types of abuse and said they would report any concerns to the registered manager or office staff. They were confident any concerns would be taken seriously and addressed. The provider told us they had "safeguarding antenna" and were always vigilant. They said they regularly spoke to staff about safeguarding and had it high on their agenda for themselves. They told us some people used CCTV cameras in their homes, which they fully agreed with. They said this ensured any concerns could be readily identified and addressed to minimise the risk of further occurrences.
● People told us they felt safe with the staff supporting them. One person said, "Yes, I feel safe. I've never felt threatened by anyone who comes here." Another person told us staff were kind and caring, and they were treated with compassion. A relative told us, "I do feel that [person] is safe with them. They do vary a bit, but most are very good."
● People's preferred choices of whether they received support from a male or female carer was respected. This enabled people to feel comfortable with those supporting them. However, one person told us staffing shortages had impacted on this.

Preventing and controlling infection
● Systems were in place to ensure the prevention and control of infection.
● There was an up to date infection prevention and control policy, but not all staff had undertaken mandatory refresher training in infection prevention and control.
● The provider and staff told us there were ample supplies of personal protective equipment (PPE), which could be easily accessed when needed.
● There was a section within people's care plans about the risk and impact of Covid-19. However, this had not been completed.
● People and their relatives generally told us staff followed good infection control practice. One person said, "[Staff member] is very clean and tidy, [they] keep everything here clean and in order." A relative said, "They're very good, they come in clean uniforms, they wear gloves, aprons and masks. They change their

gloves between tasks. They're really careful about disposing of stuff correctly and about washing their hands." There were comments however, about staff not always wearing their uniform and lowering their masks when speaking to people.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to Requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People had care plans in place, which mostly detailed preferences, health conditions and any care interventions the person needed support with. However, the impact of the health conditions, such as Parkinson's disease, and Epilepsy were not expanded upon. One person was being nursed in bed, yet there was no plan in place to inform staff how to move them safely. This did not ensure staff had the information they needed to support the person in the best possible way.
- Some information within care plans lacked detail. For example, one person had a Cancer diagnosis and experienced sickness. It was stated this was normal, but there was no information about what triggered the sickness or what could be done to help. Another care plan stated staff should assess the person's mood before progressing. There was no further clarity to show what this meant in practice. Another instruction stated, "If I appear quiet or lightheaded, please move me back to bed, raise my legs immediately." There was no further detail or clarity about this.
- The terminology within some people's daily records was at times disrespectful, not always factual or showed staff had an understanding of people's needs. This included, "[Person] wasn't himself and was kinda aggressive", and "I explained why we had to clean and change him, but he hates it and creates." Within a summary of an incident, a staff member documented a person had purposely left their stair lift in a position for the staff member to climb over. This was the staff's explanation in relation to the person's frustration of their evening care visit being late.
- The electronic care planning system required staff to confirm care tasks they had completed during the visit. They did this by submitting a tick against each task. However, not all staff had provided a written account of the support provided. Others had completed such records, but the information was task orientated and included phrases such as, "Fully body wash given, dried and creams applied." The information did not show any interactions or how the person presented.
- A relative told us about the records regarding their family member. They said, "The care records are all on the computer now, I can access them, but I find they're now very much more inaccurate than the written record used to be. It seems to be a box ticking formula, so they might tick 'bowels open' which doesn't reflect that the person was faecally incontinent several times that day, or tick mood 'happy' when the person has been miserable all day thereafter. They used to write something meaningful before."
- Records did not show staff had taken follow up action from previous concerns identified. For example, staff had identified one person had a skin tear that looked 'very sore'. There was no further detail or any future monitoring of the wound to ensure healing.

Care planning did not always clearly identify people's needs and the support they required. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, people were generally happy with their support. One person said, "I'm very happy with my own care. Nothing could be any better than it is. I would certainly recommend it to other people." Comments from relatives included, "They put [family member] first, it's person centred care. Some staff shine," and "I do recommend them and sing their praises. I wouldn't know what to do without them. We promised to keep [family member] in their [house] and they make it possible."
● The feedback was generally positive about the staff who provided support. Such comments included, "They have a lot of carers who genuinely care" and, "I've sometimes let myself in while the [staff] are there and can say that the way they deal with her, it's phenomenal." One relative told us, "It's lovely we can have 24/7 as part of our extended family, have a joke with them, not just carers part of the family." One person however, told us whilst some staff were really kind and nice, others had an 'attitude'. They told us, "I might make a comment about the best way to hoist me, or ask if the sling is on right. Some will be quite 'short' with me, and say, "I have been trained."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● The provider understood their responsibility under the Accessible Information Standards.
● The provider told us they would adapt and provide information in accordance to people's needs. They said this would include reading any information to a person, if this was the best way for them to understand.

● Information about people's communication needs were detailed in their care plan.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People were supported to maintain relationships and actively be part of their community if they so wished. This included supporting people with their shopping or going out for a coffee, as part of their care package.
● Staff told us the agency was flexible and the timings of visits could be adjusted to accommodate any appointments the person might have. One member of staff said, "We can always juggle things around if someone wants an earlier visit because of a hospital appointment or something. They are very good like that."
● The provider told us they always emphasised to staff that they needed to stay the full allocation of each person's visit. This was to develop relationships, but also to minimise the risk of social isolation. The provider told us some people had little interaction with others, so time with staff was an important part of their day.

Improving care quality in response to complaints or concerns
● Systems were in place to manage complaints or concerns.
● The provider told us they took any concerns about the service seriously. They said they listened to people and tried to resolve any issues as quickly as possible.
● People and their relatives knew how to raise a concern and had done so when required. They said if they had complained about a member of staff, they were not sent to support them anymore. However, they were not given an update, or a conclusion regarding their concern.

End of life care and support

● The registered manager told us end of life care could be provided if needed although at the time of the inspection, no one was receiving this type of care.
● End of life care formed part of the provider's training plan for staff. They told us they would also gain information about the person needs from working alongside involved health care professionals. This included community nurses and local hospices.
● The provider told us they would deploy those staff who had a particular interest or were more suited to working with people at the end of their lives. This would ensure the best use of staff's skills and enable consistency for the person.

Requires Improvement

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

- Some audits had been completed, but these were not consistent and not always identifying shortfalls such as those found within the inspection. For example, shortfalls with the recruitment process, risk management including responding to any accidents and incidents, care planning and staff training had not been identified.
- When shortfalls were identified, the provider had failed to ensure action was consistently taken to rectify the issue. For example, shortfalls such as those with the safe administration of people's medicines had been identified, but action had not always been taken to minimise a reoccurrence.
- The provider undertook people's support at times of staff shortages. They also provided transport for those staff who did not drive. These commitments impacted on their time to undertake their management responsibilities, which in turn had affected the service.
- The provider told us they were aware there were some staff who were not performing as they wanted them to. This included in areas such as commitment, motivation and attitude. The provider showed a clear desire to support these staff to ensure their wellbeing but monitoring and addressing such practice was limited.

Systems were not in place to effectively assess, monitor and improve the quality and safety of the service and there was a lack of management oversight in relation to accidents, incidents and safeguarding. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Records showed some spot checks of staff's performance were undertaken. People and their relatives confirmed this. One relative said, "The manager comes out occasionally to work with the staff and assist. She also rings quite often to see how things are going."
- The provider told us they were aware some aspects of the service had slipped, and improvements needed to be made. They said being without a deputy manager had impacted on this. After the inspection, the provider told us they were not accepting anymore care packages until they had sufficient staff to safely do so and improvements had been made.
- Records showed there were accidents and incidents, which had not been notified to CQC. This was a regulatory requirement that helps us monitor services, which the provider was not fulfilling.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009: Notification of other incidents

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

outcomes for people
● The registered manager told us they were passionate about what they did. They had strong values, and said they hoped and intended for their enthusiasm to 'rub off' on the staff team.
● There was positive feedback about the provider. This included their positive nature and attitude. Specific comments were "[Name of provider] is very hands on and approachable," and, "[Name of provider] is more open than any manager I have worked with over a 10-year period. They are very honest and transparent."
● Subjects such as people's rights, privacy and dignity, communication and equality and diversity formed part of the provider's staff training plan. This helped develop an open and empowering approach within the service. The provider told us they made sure staff were well trained before supporting people. However, staff training records did not evidence this. They said there was an expectation of ongoing learning, role modelling and regular discussions about people's needs and the best way to support them.
● There was an on-call service, which operated outside of office hours. Staff told us the provider was also always contactable, gave good advice and listened to what they had to say.
● Staff told us they enjoyed their role and felt very well supported by the provider. They said they were provided with everything they needed to complete their role effectively. One staff member said, "They help you do your best. Help you do the best you can do for people." The provider confirmed they gave emphasis to supporting staff and ensuring their wellbeing. They included regular catch ups and initiatives such as Employee of the month.
● There were various cards and letters in the office from people and their relatives, thanking staff for the support they had given. The information showed the service had made a difference to people's lives.

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
● The provider understood their responsibilities regarding the duty of candour. However, these were not always applied in practice.
● People and their relatives told us they were confident the provider would act on anything that had gone wrong. However, they had not always been given an update or information about any conclusion. One relative told us, "A report was made. It didn't seem to go any further. I haven't heard from the office, nobody made an apology, nobody came out."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, Working in partnership with others
● People, their relatives and staff were encouraged to give feedback about the service. This was through general conversation, phone calls, surveys and care reviews.
● The service worked alongside other agencies such as commissioning, the local authority, GPs, community nurses, occupational therapists and the speech and language team. The provider told us there was also close liaison with local hospitals, in the event of a person being discharged to their care package at home. A relative confirmed this and said, "They work well with the GP, nurses and continence team etc."
● The provider told us they were a member of local care industry associations. This enabled information sharing, training and support from other managers.
● One professional told us the provider was, "Caring, very hard working" and they, "Meant well." They said the provider spent much of their time covering care calls, and making sure people were happy with the service they received. They said the provider was always very accommodating to accept more care packages, although this was at times to their detriment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Incidents and accidents were not always reported to the Care Commission as required. Regulation 18(1)(2)(1)(5)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care planning did not always clearly identify people's needs and the support they required. Regulation 9 (3)(b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to identify, assess and mitigate risks to people's safety. Regulation 12 (1)(2)(a)(b) Systems had not been effectively established to ensure the safe administration of people's medicines. Regulation 12 (1)(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good

governance

Systems were not in place to effectively assess, monitor and improve the quality and safety of the service and there was a lack of management oversight in relation to accidents, incidents and safeguarding.

Regulation 17 (1)(2)(a)