Exodus Homecare Agency Limited

Exodus Homecare Agency

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

Summary of findings

Overall summary

About the service
Exodus Homecare Agency is a domiciliary care agency providing personal care in people's own homes. 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.

At the time of the inspection the agency was providing a service to five younger and older adults some of whom were living with dementia and some who had a disability.

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

We found that the not all staff recruitment was undertaken in a robust manner because the provider allowed staff to work prior to references being received. However, all other recruitment checks were undertaken. At the time of our inspection the provider had a limited team of care workers, however care calls were met because the nominated individual worked with people in their homes.

People were supported to have maximum choice and control of their lives and staff supported support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Most people using the service had capacity and had consented to their care and treatment. However, we found one instance where the provider was not working in line with the Mental Capacity Act 2005.

People and their relatives spoke very positively about the care they received. They told us staff were very "kind" and "caring". People's communication support needs were recorded to ensure they could make informed choices.

People had person centred care plans that specified how they wanted their care provided. Care plans were reviewed on a regular basis to ensure they were still relevant to the person.

People using the service and their relatives felt safe. The registered manager assessed people prior to offering a placement and put in measures to address any risks to the person.

Staff supported people to have choice and control of their lives and respected their dignity and privacy; 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

Why we inspected
This service had been dormant. This meant they had not been providing care to anyone. Therefore, this is

the first inspection under our new methodology ratings.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was 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.

Exodus Homecare Agency

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 Care Act 2014.

Inspection team
One inspector carried out this inspection.

Service and service type
Exodus Homecare Agency is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider would be in the office to support the inspection.

Inspection activity started on 11 June 2019. We visited the office location on 11 June and made telephone calls to people and their relatives following our inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with one person who used the service and three people's relatives. We met the nominated individual during our site visit. The nominated individual is responsible for supervising the management of the service on behalf of the provider. The nominated manager was also the registered manager. Throughout the report we will refer to the nominated individual as the registered manager. We also spoke with the duty officer and the administration officer.
We reviewed a range of records. This included two people's care records and associated records such as daily notes. We looked at one other person's medicines records. We viewed three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
Following the inspection, we telephoned and attempted to speak with a care worker but were unsuccessful. We telephoned and spoke with the field officer.

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection for this service under our new methodology. This key question has been rated 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.

Staffing and recruitment

●The provider did not ensure the safe recruitment of staff was carried out in a robust manner. This was because two staff had been employed prior to their references being received. This meant the provider did not have confirmation of their work history and practice.

● One staff member had commenced working prior to their employment reference being received. We saw that there was difficulty obtaining their work reference from their previous employer as the company had ceased trading. The provider had persisted in asking for a reference and it was received and approved on the 10 June 2019. However, the staff had commenced working prior to this. The staff call signing in log evidenced they were working on the 13 May 2019.

●A second staff member had also commenced work prior to both their references being obtained. Requests for references were requested on the 20th May 2019. However, the signing in log showed the staff member was working 10, 11, 12 and 13 of May. In addition, a provider's spot check also cites the staff member as working on the 10 May 2019.

●The registered manager told us following the inspection that due to pressures of providing cover in an emergency the staff members had been engaged after the criminal record check were received but prior to references being obtained. They stated they had also obtained verbal references, but these had not been recorded. They explained this had ensured people's needs were met and they felt people were not placed at risk. They had since our visit reviewed their recruitment practice.

This was a breach of Regulation 19 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Notwithstanding the above other recruitment procedures were undertaken. Prospective staff completed an application form and attended an interview. Criminal records check and proof of identity and right to work in the UK were obtained.

● People and relatives told us that staff mostly arrived and stayed for the agreed amount of time. One relative said for example, "Generally they come on time, if they come late they do make up the time." We saw that lateness to care calls had been raised as a concern in February 2019 by a local authority social services team. The registered manager told us they had addressed this issue with the staff member. When possible, they paired staff with other staff who were a car user, and this had minimised lateness.

● The office staff monitored the call logs records signed by staff. There were instructions on these records that stated, "Please ensure Clients sign each Login/Log out session during every shift. Any sessions that are

not signed will not be accounted for." However, we noted, for one person the records did not contain any signature for nine days in May and June 2019

●The registered manager explained as they were supporting a small number of people the office staff phoned care workers to check if they have arrived at their care call. They also undertook unannounced staff spot checks. We saw that people and relatives were asked for feedback and staff performance was monitored. The provider had purchased an electronic call monitoring system that would enable them once the business grew to monitor care calls more effectively.

● One relative felt care worker numbers should be increased as there were few care workers to cover when one was on holiday. However, they confirmed staff arrived on time and there were no missed calls. The registered manager told us that currently there was a staff team of seven in total. This included four office staff and three designated care workers who worked with five people receiving care. They explained the number of permanent care workers had fallen recently. To manage the care calls care workers who had worked for them in the past returned to cover occasional shifts if permanent staff were absent. In addition, the field officer and the registered manager provided, "Hands on" care, often at the weekends.

Using medicines safely

● Most people who used the service were not provided with medicines support from Exodus Homecare Agency. People's care plans described who was responsible or if the person was able to manage their medicines without support. One person required care workers to remind them to take their medicines. This was written in their care plan and care workers completed medicine records (MARs) to demonstrate they had reminded the person.

● We were only able therefore to review the small sample of MARs available. The registered manager had checked to ensure care workers had completed the MARs appropriately. They reviewed medicines care plans to ensure existing arrangements were still safe. For example, they had supported one relative by purchasing a Dossett box, that contained compartments denoting times and days of the week, so they could organise their family members medicines more effectively.

Systems and processes to safeguard people from the risk of abuse

●The provider had systems in place to keep people safe from abuse. Care staff had received safeguarding adult training and were able to tell us how they would recognise signs of abuse and report possible concerns to the registered manager.

● People and relatives confirmed they felt that care was provided in a safe way. Their comments included, "Absolutely safe" and "Yes, definitely safe." The registered manager told us they reviewed people daily notes and checked accidents and incidents records to ensure safeguarding concerns were reported. They described they provided hands on care to people during the weekend and took this opportunity to speak with people and relatives and check any signs of abuse were reported appropriately.

Assessing risk, safety monitoring and management

● The registered manager assessed prior to offering a service to identify risks to people. These included risks in the environment, medicines, pressure ulcers, use of bedrails and behaviours that challenge. Risks were high-lighted, and measures were put in place. This included for example, care plans stating two staff were required during personal care and stated the equipment to be used.

●However, some further guidance about behaviours that challenged would have further supported staff. Whilst the risk of agitated behaviour was documented the guidance to staff was to reassure the person. More detailed guidance would support staff to manage behaviours more effectively. We brought this to the nominated individual's attention, they told us about the positive measures staff had taken to work more effectively with people, but these measures were not recorded in the guidance for all staff to access.

Preventing and controlling infection

● The care workers received infection control training prior to commencing their role. People and their relatives confirmed that staff brought with them personal protective equipment (PPE) that included gloves. Their comments included, "They wear gloves," and "Yes, they use disposable gloves." Care workers confirmed the provider ensured they had adequate supplies of PPE.

Learning lessons when things go wrong

●The registered manager described how they would investigate and write a report should a near miss or an error take place. They told us that they would hold an emergency staff meeting to discuss the issue and speak with individual staff involved and provide training. They would update their procedures to prevent a reoccurrence if this was appropriate.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this service under our new methodology. This key question has been rated requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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.

●Information on people's care plans prompted that if there was a relative who had lasting power of attorney (LPA) a copy of the LPA must be provided. A lasting power of attorney (LPA) is a legal document that lets a person (the 'donor') appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf.
●We saw that one person's relative had signed their care plan and a notice of an advocate, stating they were the advocate. However, no copy of LPA was available in the person's records to confirm that the relative had the legal right to make decisions on the person's behalf.
●The registered manager told us they thought the relative did have a LPA. We asked for evidence of this to be sent to us. However, this was not provided at the time of writing this report. Therefore, we could not be assured that the provider had taken all the necessary steps to ensure they were working in line with the MCA.

This was a breach of Regulation 11 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People who had the capacity to do so had signed consent forms to consent to their care and treatment, information sharing and medicines administration. These were resigned each year. Care plans referred to people's mental capacity and stated for example that whilst someone have some level of dementia they were still able to make autonomous decisions with minimal support.

● The field co-ordinator told us that they offer people choices and if they refused care they would listen to them. They said, "If they say no, then it is no. You cannot force them." They continued to explain that they would encourage the person and offer an alternative that they might prefer, such as, a strip wash when they have refused a shower.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● At the time of our inspection all people receiving a service were referred by local authorities. The demonstrated they met with people and their relatives to assess them prior to offering a service. This was to confirm what care they required and how they wanted their care provided.
●People and relatives told us the registered manager had visited them to assess. One relative said, "Yes I believe they did an assessment before and visited [family member]," and "Yes [Registered manager] does an assessment and every six months or so reviews and we sign." Care plans contained relevant information to support the care workers to understand the person and their care needs. Care plans and risk assessments were reviewed on a regular basis and in response to changing circumstances to ensure they still met people's care and support requirements.

Staff support: induction, training, skills and experience
● Staff received an induction and training to support them to undertake their role. Induction training included, manual handling, first aid, health care legislation, and health and safety. The field co-ordinator described that care workers shadowed them and more experienced staff. The field co-ordinator assessed the care workers to ensure they were competent to work independently. They also asked staff if they felt they required more time to feel confident and would provide this if appropriate.
● Staff completed the Care Certificates to support them to undertake their role. These are nationally recognised health and social care standards. The training included safeguarding adults, MCA and diversity and equality. The registered manager told us most of the training had been delivered through e-learning, but they had started to commission face to face training. This was to give care workers the chance to ask questions and discuss the subject matter more fully with trainers.
●In addition, to formal training care workers were assigned policies to read and sign. These included, infection control, pressure ulcer management, food and nutrition and whistle blowing. The Registered manager described that they went through policies with individuals staff members during their induction. Training need was also identified through supervision sessions. We saw two care workers had requested additional safeguarding adults training and the registered person told us this was being arranged.

Supporting people to eat and drink enough to maintain a balanced diet
● People at the time of our inspection did not require assistance from the care staff to eat their food or prepare their meals. One person whose relative cooked for them was prompted by both the relative and care staff to eat and drink but required no other assistance. We saw that their care plan recorded this clearly and informed staff their relative prepared food in-line with the person's cultural preferences. However, we were not able to further assess this key question.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● The registered manager and office team ensured that staff had relevant information about people's health conditions. The duty officer told us, "Information is the key to good care." Factsheets provided included information about depression, diabetes, high blood pressure and Alzheimer's disease. Staff were therefore aware of possible symptoms of ill health and were able to report concerns appropriately.
● Staff took appropriate actions and contacted relevant health professionals when people were ill. The field co-ordinator told us when one person had a pressure ulcer following a hospital discharge they had reported

this to the GP and district nurses. On another occasion they arrived to find another person unwell. They took appropriate actions to support the person to be more comfortable and they phoned the emergency services which conveyed the person to hospital. On each occasion they had informed relatives and reported to the office staff.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this service under our new methodology. This key question has been rated good

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People and relatives spoke positively about the care workers. Their comments included, "They are very good and very kind," and "We find they are very caring and helpful." Recorded feedback from people and relatives in spot checks and questionnaires was also positive and complimentary describing being treated with respect.
- People had person centred care plans that described people in positive terms. Recognising and stating their positive traits. For example, that they have a, "bubbly personality." Care plans contained objectives that included, "Ensure [Person's] dignity and choices are being respected." There was some information about people's diverse needs recorded in their care plans. For example, one person's plan stated their religion and their place of worship and stated who supported them to attend.

Supporting people to express their views and be involved in making decisions about their care;

- Both field and office staff spoke respectfully about the people who used the service. The field co-ordinator told us that they made sure they were face to face with people when they spoke with them and did not stand over people but knelt or sat on a chair, so they had eye contact with the person. They said this helped promote good communication and showed they were listening to what the person was saying.
- The registered manager told us that when possible, "We match service users to the care worker. Some are chatty or some quieter. If they click they work well." The field co-ordinator described how they gave people choices. For example, they might open the fridge and show or describe breakfast choices or take out three sets of clothes, so the person can make their own choice about what they want to wear.

Respecting and promoting people's privacy, dignity and independence

- People and carers told us care was provided in an appropriate manner. This included ensuring people's dignity and privacy was maintained. One relative told us, "They are very good about privacy," and one person said "Yes [Care worker] make sure I'm am [private]."
- People's care plans stated what they could do for themselves. For example, that they could choose their own clothes and that people's choices were to be respected. The field co-ordinator told us that they encourage people to do what they can for their self-respect. They told us, "They are a human being, sometimes they just want to talk. So, I do give them time."

Good

Is the service responsive?

Our findings

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

This is the first inspection for this service under our new methodology. This key question has been rated good

This meant people's needs were met through good organisation and delivery.

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

● People had person centred care plans. The plans contained information about people's history and their family, naming people who were important in their lives. This helped care workers understand people within the context of their life. In addition, there was a brief profile that described what support the person required in a quick and accessible way.

● Care plans detailed how personal care was to be provided and the equipment to use was specified. For example, if a profiling bed, shower chair or a hoist was used. Care plans stressed throughout that it was the person's choice as to how their care was provided. Personal choice was promoted and the need for the person to be "comfortable" and "autonomous" was reiterated.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● All care staff attended communication training as part of their induction. In addition, some staff had attended specific training to support them to communicate more effectively with hearing impaired people. The field co-ordinator described how they communicated with one person by writing down what they wanted to convey. They also used a booklet with symbols denoting for example, types of meals, standing up or showering. This supported the person to understand what was being requested by staff and allowed them to respond with their choice.

●Care plans contained relevant information informing staff what support they required to make a choice. For example, one care plan provided guidance for care workers to speak in a tone where the person could hear them. Other plans specified equipment including glasses, hearing aids and dentures that people required to make themselves understood.

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's care plans we reviewed contained their social activities preferences. For example, to have care staff support to go for a walk and buy a specific newspaper and to do word games and have conversations. Daily notes evidenced this took place.

●The registered manager was supporting one person's relative to identify a suitable day placement where

the person could socialise with others and take part in organised activities. This was also to be an opportunity for their relative to pursue their own activities and have respite from their caring role.

Improving care quality in response to complaints or concerns

● The registered manager told us that they had received no formal complaints but clarified that any concerns raised were addressed immediately. They described how they would address a formal complaint stating that they would visit the person immediately to find out what had taken place. Remove or suspend the care worker whilst investigations were carried out. Apologise to the person and take actions to address the concern and to prevent a reoccurrence.

●People and relatives told us they knew how to raise a complaint. Most spoken with felt if they made a complaint the registered manager would be receptive, and it would be dealt with quickly. One relative told us, "If there was a problem it would be dealt with, no doubt about it, [Registered manager] is very approachable."

End of life care and support

● The registered manager told us there was no one receiving palliative care at the time of our inspection. They had recognised the need to provide staff with further skills and as such were working with a consultant, so staff could access appropriate end of life training.

●The duty officer told us they would assess the person to have an end of life care plan. This would detail people's wishes and they would involve family members. The aim would be to make people as comfortable as possible. The registered person explained they would work alongside health professionals including district nurses and palliative community nurses.

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.

This is the first inspection for this service under our new methodology. This key question has been rated 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

- At this inspection we found there were some shortfalls regarding staff references not being received prior to the staff commencing their role. In addition, a relative was signing consent for their family member but LPA had not been verified by the provider. Risk assessments were generally detailed, but we found that more guidance was required to support staff to manage behaviours that challenge.
- However, notwithstanding the above we found that checks were taking place to assure the quality of the service provided. The registered manager visited people and provided care. They used these occasions to check people and relatives were satisfied with the care provided. Unannounced spot checks took place to check staff were working to the providers expectations. We saw that during spot checks people were asked if they felt staff were honest and treated them with respect to establish if there were any concerns.
- The registered manager audited daily notes, medicines records and care records. They and the duty officer and the field co-ordinator reviewed people's care plans on a regular basis. The nominated person was working with a training consultant to ensure the quality of the training provided for staff and had identified the need for more face to face training.
- There were well defined roles within the office team. The duty officer focussed on the day to day management of the care calls and associated care management. The registered manager took a management role making decisions and having oversight of the business development. They also provided, "hands on" care as did the field co-ordinator who worked alongside staff to support and supervise. They undertook assessments and reviews. There was an administration officer to assist with office processes.

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 registered manager told us that they aimed to be open and transparent in their dealings with people. They gave an example of responding to the local authority social services team when there was a concern raised about staff attendance times. They had investigated and addressed the issue.
- The duty officer and the registered manager were able to demonstrate they knew what the CQC must be notified about by law and understood their role in keeping us informed in a timely and transparent manner.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering

their equality characteristics

● People and relatives spoke positively about the service they received. One relative said, for example, that it was, "Very good, very warm and caring. Do job fantastically." People and relatives knew who the nominated individual was as they visited to provide care on a regular basis. This gave people an opportunity to discuss concerns directly with the provider and facilitated a person- centred approach to providing care.

●We saw that on occasion the provider had advocated successfully for individuals using the service. For example, when one person was isolated and lonely they had flagged this with social services. They supported them to receive a daily care call that included support to socialise. This had enhanced the person's daily activities with others and supported them to go out into their local community.

●We saw that people's diverse support needs were stated in their care plans. In most instances people were being supported by their family members to meet these needs. These included, their religious and cultural observances. Care plans stated where English was not a first language and the nominated person told us they try to recruit staff to speak to people in their preferred language. The service had provided questionnaires and feedback with symbols to support people to comment when English was not their first language.

● Staff were supported by the registered manager, the duty officer and field co-ordinator. They attended regular meetings. The registered manager and field co-ordinator acted as a role model when working with staff to promote good practice and maintain a consistency of approach. Staff were able to speak with them and raise concerns on those occasions.

●Communication with staff in the field was undertaken by mobile telephone, using text and email. The provider recognising that not all staff had access to 'smart' mobile phones gave them work mobiles if this was required. They had a contract with a phone contractor and supported staff by providing limited free text and phone calls. This ensured they were always contactable should the need arise.

Continuous learning and improving care

● The registered manager told us they maintained their own knowledge through e-learning and reading current research, books and social care related articles. They subscribed to Home Care UK and Home Care Insight. They used Social Care Institute for Excellence (SCIE) online and were members of Dementia Concern. They said they found this valuable in keeping themselves and the supporting staff up to date with current issues.

Working in partnership with others

●The registered manager said they worked in partnership with people and their families. They liaised with social care and health professionals on people's behalf. They were working with a training consultancy company to develop staff training and knowledge.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not got systems in place to ensure they were working in-line with the Mental Capacity Act 2005

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not undertaken all the necessary checks to ensure the safe employment of staff. Regulation 19(1)