Compleat Care (UK) Limited

Homecare Helpline

Inspection report

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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

Homecare Helpline is registered to provide personal care to older people, people living with dementia and people with a physical disability. Most of the people who use the service live independently in their own home although the service also provides support to some people who live in an 'extra care' sheltered housing service in Grantham. The service has operated for many years in the Spalding, Stamford and Bourne areas of Lincolnshire. In October 2015, following a reorganisation of domiciliary care services by Lincolnshire County Council, the service expanded significantly to take on a major new contract in the Grantham area.

We carried out an unannounced comprehensive inspection of the service on 6 April 2016. At this inspection we found three breaches of legal requirements. This was because staffing resources were not organised safely, service delivery was not monitored effectively and the registered provider ('the provider') had failed to notify us of significant incidents relating to the service.

After this inspection, the provider wrote to us to tell us what they would do to address these breaches. We undertook this focused, follow-up inspection on 8 December 2016 to check that they had followed their plan and to ascertain that legal requirements were now being met. At the time of this inspection approximately 300 people were receiving a personal care service.

This report only covers our findings in relation to these issues. You can read the report from our comprehensive inspection by entering 'Homecare Helpline' into the search engine on our website at www.cqc.org.uk.

At our focused inspection of 8 December 2016 we found that the provider had not addressed two of the three breaches of legal requirements we identified in April 2016.

There was an ongoing failure to ensure the safe and effective organisation of staffing resources and scheduling of care calls to meet people's needs and preferences. There was also an ongoing failure to notify us of significant issues involving people using the service.

We have taken action against the registered provider to ensure that they make the necessary improvements to become compliant with legal requirements. You can see what action we have taken at the end of the full version of this report.

We found that the provider had made changes to the monitoring and auditing of service delivery and legal requirements in this area were now met. The provider had a clearer understanding of people's experience of using the service and was committed to addressing their continued dissatisfaction with the deployment of staff and call scheduling.

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

We found that the provider had taken insufficient action to improve the safety of the service.

There was a continuing failure to ensure the safe and effective organisation of staffing resources and scheduling of care calls to meet people's needs and preferences.

This meant that the provider remained in breach of legal requirements.

Is the service well-led?

Requires Improvement

We found that the provider had taken insufficient action to ensure the service was well-led.

There was a continuing failure to notify us of significant issues involving people using the service.

This meant that the provider remained in breach of legal requirements in this area.

Action had been taken to improve the monitoring of service quality. This meant that the provider was now meeting legal requirements in this area.

Homecare Helpline

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 was 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.

We undertook a focused, follow-up inspection of Homecare Helpline on 8 December 2016. This was to check that the provider had addressed the three breaches of legal requirements we had identified at our comprehensive inspection of 6 April 2016.

The inspection was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service. We did this because the registered manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that they would be available to contribute to the inspection.

We inspected the service against two of the five questions we ask about services: 'Is the service safe?' and 'Is the service well-led?'. This is because the service was not meeting legal requirements in relation to each of these questions.

The inspection team consisted of one 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. On 7 and 8 December 2016 our expert by experience telephoned people who used the service to seek their views about how well the service was meeting their needs. Our inspector visited the administration office of the service on 8 December 2016.

Before our inspection we reviewed the information we held about the service. This included the information the provider had sent us following our inspection in April 2016, setting out the action they would take to meet legal requirements. We also considered notifications received (events which happened in the service that the provider is required to tell us about) and information that had been sent to us by other agencies.

As part of our inspection we spoke with nine people who used the service, two relatives, the registered

manager, the managing director of the registered provider and three care workers. We looked at a variety of documents and written records including staff duty rotas and information relating to the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

When we conducted our comprehensive inspection of the service on 6 April 2016 we found that the provider had failed to ensure the safe and effective organisation of staffing resources and scheduling of care calls across the service. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to this breach, the provider told us that they would be making changes to the way care calls were scheduled and care staff organised. The action plan submitted by the provider at this time stated, "The aim will be to achieve fixed rounds, with main carers, supported by regular relief staff that attend calls at the desired time."

However, almost everyone we talked with as part of our follow up inspection on 8 December 2016 told us they were unhappy with the scheduling of care calls and the negative impact this had on their lives. In particular, people told us that care staff were often late arriving at their home. For example, one person said, "I never know what time they are coming." Another person told us, "I really wish they weren't late for the morning call as I can't get out of bed without them. And when they have been late I've had to cancel appointments." One relative told us, "This is my biggest bug bear. We never know what time they are coming. They are supposed to come around 9.20am but it can be anytime from then to 12 noon."

People also told us of their frustrations at the lack of staffing continuity. For example, one person said, "The staff don't seem to know when they are coming and I don't know who is coming. It would be nice to have some sort of rota to know who's coming when." Another person told us, "I see lots of different staff. They seem to have a very high turnover of staff. I really don't see them enough [to get to know them] as they are always changing." Another person's relative said, "My mother usually sees around eight different carers. She is getting confused now and it would be less confusing for her to have regular carers." Some people also expressed concern at the provider's failure to meet their request for gender-specific care staff. For example, one person told us, "They know I prefer women. They once sent a man. They didn't ring, they just turned up." Another person said, "They sent a man once without asking. I told them I wanted a woman [and] the carer just left. Luckily my son was here to help put me to bed."

Reflecting their dissatisfaction with the way staffing resources were organised and care calls scheduled, most people we spoke with felt unable to recommend the service to others. For example, one person told us, "They don't seem to have enough staff for the people they have on their books at the minute." Another person said, "[The service] doesn't seem to be well-organised and there seems to be a high turnover of unhappy staff." Another person said, "They are short of staff. They can't keep the good staff. And they are late." Commenting on the performance of the service in the period since our last inspection in April 2016, one person told us, "It improved for a little bit. I was getting the same carers. But it's gone bad again now."

When we discussed these concerns with the registered manager and the managing director they outlined the changes they had made to address the breach of regulations identified at our last inspection. These included the introduction of electronic call monitoring, improved performance management of staff

absence and changes to the staffing structure within care teams and the administration office. However, reflecting the feedback we received from people using the service, they acknowledged that further work was required to ensure the safe, reliable scheduling of care calls to meet people's needs and expectations. In particular, to ensure the service had sufficient staff by addressing a recent increase in staff sickness and improving recruitment in some areas. The managing director told us, "If we are honest, it's not where we want it to be. We need to come up with a solution. We need to recruit staff, support and retain them." As further confirmation that improvement was still required, when we reviewed the percentage of late calls (defined as late by 20 minutes or more), we saw that this was still at a very similar level as at the time of our last inspection - 14.3% of all calls in April 2016 compared to 13.1% in November 2016. This meant there 2832 late calls recorded in November 2016.

The provider's ongoing failure to ensure the safe and effective organisation of staffing resources and scheduling of care calls across the service was a continued breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

When we conducted our comprehensive inspection of the service on 6 April 2016 we found that the provider had failed to notify us of several allegations of abuse involving people using the service which had been considered by the local authority under its adult safeguarding procedures. This was a breach of Regulation 18(2)(e) of the Care Quality Commission (Registration) Regulations 2009.

In response to this breach, the provider told us that they had introduced a new system to ensure any significant issues involving people using the service were notified to CQC, as required by the law.

However, in preparation for our follow up inspection of 8 December 2016, we identified that there had been a further seven occasions since April 2016 when the provider had failed to notify us of allegations of abuse against people using the service. During our inspection visit, we discussed this issue with the registered manager who acknowledged that the new system was clearly not working effectively.

The provider's ongoing failure to notify us of significant issues involving people using the service was a continued breach of Regulation 18(2)(e) of the Care Quality Commission (Registration) Regulations 2009.

On our inspection of 6 April 2016 we also found that the provider had failed to monitor service delivery effectively or respond to issues of concern which had led to shortfalls against legal requirements in the provision of care to the people using the service. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On our follow-up inspection of 8 December 2016, the provider outlined the changes they had made to the monitoring and auditing of service delivery to address the breach. For example, the managing director told us that a new customer satisfaction questionnaire had been designed and was in the process of being rolled out across the service. Although, at the time of our inspection, there had been insufficient returns received to establish any clear themes or trends, the managing director told us he was confident that the new approach would provide a more detailed understanding of people's experience of using the service, allowing a more targeted response. We looked at some of the comments people had submitted on the previous satisfaction survey form and saw that these had all been reviewed and followed up. For example, one person had asked that care staff were given clearer directions to their house, to avoid them arriving late as a result of getting lost. This request had been picked up and addressed by the provider. The registered manager told us that she had also introduced a new approach to auditing staff personnel files to ensure mandatory training and supervisions and appraisals were up to date. As part of this new approach she also reviewed people's care files to make sure they contained all necessary documentation. In response to a suggestion from our inspector, the registered manager agreed to increase the frequency of these audits to ensure any shortfalls were picked up more quickly.

Although further work was needed to fully establish these new quality monitoring systems, we found that the provider had taken sufficient action to address the breach of Regulation 17(1). In comparison to our last inspection in April 2016, the provider had a much clearer understanding of people's experience of using the

service and was committed to addressing their continued dissatisfaction with staff deployment and call scheduling. Acknowledging that some people were still not receiving the quality of service they were entitled to expect, the managing director said, "[We] are not where we want to be yet. Getting the right amount of staff [is like] shifting sands. [But we are trying] to get our systems and structures in place … to get that steady continuity."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider's continuing failure to notify us of significant issues involving people using the service.

The enforcement action we took:

Fixed Penalty Notice in the sum of £1250 regarding the failure to notify CQC of allegations of abuse concerning people using the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider's continuing failure to ensure the safe and effective organisation of staffing resources and scheduling of care calls to meet people's needs and preferences.

The enforcement action we took:

Warning Notice regarding the failure to ensure the safe and effective organisation of staffing resources and scheduling of care calls.