Orchard Homecare Services Limited

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Inspection report

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11 December 2019
16 December 2019
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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Orchard Homecare is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to younger and older adults. At the time of inspection 250 people were 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
At this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment and governance.

People said they felt safe with the service provided. However, systems were not robust and staff deployment was not effective to ensure people's needs were met in a safe, timely and consistent way.

Records did not provide guidance to staff to ensure people received safe, person-centred, appropriate care and support. Systems were not all in place for people to receive their medicines in a safe way.

A robust quality assurance system was not in place to assess the standards of care in the service. Audits that were carried out were not effective as they had not identified issues that we found at inspection.

Systems were not all in place to treat all people with dignity and respect to ensure they were kept informed and received consistent care from the same staff, with choice of gender of carer.

Information was not always accessible to involve people in decision making about their lives.

People had the opportunity to give their views about the service. There was consultation with staff and people. People said they knew how to complain. However, some people and relatives said they did not always feel listened to.

People were not always supported to have maximum choice and control of their lives, staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff knew about safeguarding procedures. There were other opportunities for staff to receive training. Staff worked well with other agencies to ensure people received care and support.

All people and relatives were complimentary about the direct care provided by support staff. They trusted

the workers who supported them. They said staff were kind, caring and supportive of people and their families.

Staff said they felt well-supported by the organisation and were aware of their responsibility to share any concerns about the care provided.

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 21June 2017).

Why we inspected

This was a planned inspection based on the previous rating.

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?

Requires Improvement

The service was not always caring.

Details are in our caring 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

Orchard Home Care Services Limited

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
The inspection was carried out by an inspector and an Expert-by Experience who carried out telephone interviews. 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.

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
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 11 December 2019 and ended on 16 January 2020. We visited the office location on 11 December 2019.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 of this information to plan our inspection.

During the inspection
We spoke with the provider and registered manager. We reviewed a range of records. This included six people's care records and five medicines records. We looked at three staff files in relation to recruitment and staff training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
After the site visit we tried to contact 50 people who used the service by telephone. We spoke with 10 people and 11 relatives of people who used the service. We spoke with one care co-ordinator and nine support workers. 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.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated 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.

Staffing and recruitment

● Although most people told us they felt safe, systems were not in place and staff were not appropriately deployed to ensure people received safe, timely and consistent care from the same workers who knew people's needs.

● Several people and relatives told us there were issues regarding the variety of carers, numbers of carers and the timings of their calls. One relative told us, "I have had to make several complaints about timings of calls." A person said, "I wanted an early call and didn't get one, it upset me as I had a hospital appointment, luckily my friend helped me" and "Sometimes the carers are late, [Name] isn't informed and gets upset."

● As calls were late this had an impact upon the time some people received their support with medicines, so they were not always received at the intended time. One relative said, "Sometimes the first call is really late for {Name]'s painkillers and only a short time before the next call, so it's too soon to take the next medicines." Another said, "Calls can be late by an hour, has an impact on medicines." Some relatives and people told us there had been missed calls. One relative commented, "There have been a few times the carers haven't turned up, other times two or three turn up." Another relative said, "Sometimes carers are late and have not turned up, apparently they forgot. There is still a problem with this" and "I used to be happy, but second time there has been a no show." These comments were followed up with the registered manager immediately after receiving people's feedback.

● Staff were not routinely allocated to the same people with the same staff providing continuity of care at each visit. Several people told us, "Never introduced to any new carer, they just arrive" and "I have made several complaints over the last year, one thing was not knowing who was coming, I was told a roster would be e mailed, I got it once."

● Most people said workers stayed for the correct amount of time. One relative commented, "I have complained staff don't always stay the correct time, they always seem in a rush" and "I think the carers have so much on their roster they don't have time to talk." Other people and relatives told us they trusted staff. One person said, "I have a lot of trust in my main carer" and "The girls are brilliant they make me feel safe."

Systems and processes to safeguard people from the risk of abuse

● Systems needed to be more robust to minimise the risk of abuse. There were incidents where carers had entered people's houses when the property was empty, as the person was not there. Due to ineffective communication from the office, the worker had not been informed the call was cancelled.

● Safeguarding incidents needed to show evidence of a more thorough investigation with any lessons learned and individual incidents not reviewed in isolation.

● Staff were aware of the signs of abuse. Memos to staff showed staff were being reminded of safeguarding and how to raise concerns. More regular training or systems should be in place, such as through

supervisions or staff meetings, to ensure all staff were aware of their responsibility to raise any safeguarding concerns.

Learning lessons when things go wrong

● Systems were not effective for making improvements for the monitoring of late and missed calls to ensure people received safe care and support. Individual incidents were reviewed, with corrective measures taken individually. However, analysis of groups of incidents did not take place such as for safeguardings and complaints, which looked for any trends and patterns with action being taken to reduce their likelihood of re-occurrence.

Using medicines safely

● Due to the lateness of some calls people did not always receive their medicines in a safe and timely way, where support was required. Another person told us, "My relative sorts my medicines and puts it on the table for me, if they haven't one of the staff always does this so I get them."

Assessing risk, safety monitoring and management

● Risks to people's safety had been identified but more guidance was needed to reduce or manage hazards. Risk assessments did not provide staff with a clear description of any identified risk and specific guidance on how people should be supported in relation to the identified risk. For example, for distressed behaviours and risk of choking.

● A system of reviewing risk assessments was in place but they needed more regular evaluation to ensure they remained current.

● Records showed some people became upset and distressed. The staff training matrix showed all staff had not received positive behaviour support training to give them more understanding about behaviours that challenge.

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

● There were safe and effective recruitment practices in place. Interview notes showed only one staff member interviewed prospective staff. We discussed that two staff members interviewing prospective staff promoted equal opportunities and safeguarded people. Straight after the inspection we were informed this was taking place.

Preventing and controlling infection

● Measures were in place to control and prevent the spread of infection.

● Staff received training in infection control to make them aware of best practice. Disposable gloves and aprons were available to help reduce the spread of infection.

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.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments were carried out to identify people's support needs. However, this information, where there was an identified need, was not transferred into a care plan to provide guidance to staff as they delivered people's care.

Supporting people to eat and drink enough to maintain a balanced diet
● Improvements were required to record keeping to ensure people were supported effectively with their nutrition. For example, for one person a care plan was not in place to show how to support the person with a soft diet and guidance was not available to show staff why supervision was needed with eating. For another person a relative said, "Sometimes [Name] can be difficult and say they don't want anything to eat. I have asked staff to always leave food out, there is plenty to choose from, they are doing this now I've asked them."
● Information about people's food likes /dislikes and dietary requirements was not available for staff. One relative commented, "I have notes all over, in particular about what food to give [Name] and make sure I leave something, only it doesn't always happen."

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People told us they were supported to maintain their health and well-being. However, care plans were not in place to promote their health and well-being.
● The agency received an assessment that identified people's needs from the referring agency. Care plans were not put into place from this information to ensure person-centred and consistent care was provided. For example, for catheter care, medicines, mobility.
● Staff had developed links with health care professionals to obtain specialist advice and support. A relative commented, "Staff keep good records of any pressure areas for the district nurse who comes in daily."
● Where there was a specialist care need such as for mental health or nutrition, a record of the specialist advice was not available, to show why people needed particular support.

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.

We checked whether the service was working within the principles of the MCA.
● No one was subject to any restrictions under the MCA.
● Staff had received training about the MCA.
● Information was available from the referring agency about people's capacity to consent. However, the agency's records did not show, where people may not have capacity to consent, that people's capacity to consent to various aspects of care or treatment had been assessed. Where people no longer had capacity to consent records did not show who was responsible for decision making with regard to care, welfare and finances, when formal arrangements had been made with the Court of Protection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff received training that included training in safe working practices. A staff member commented, "We do get lots of training." A relative said, "The staff all seem trained and keep good records in the books."
● The staff training matrix did not show that all staff received regular training including for any specialist needs to ensure an insight into people's support requirements. For example, distressed behaviours and end-of- life care.
● New staff completed a comprehensive induction, including the Care Certificate and worked with experienced staff members to learn about their role.
● Staff told us they felt well-supported. They all said they were fully confident to approach the management team for additional support at any time.

Requires Improvement

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.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Improvements were required as systems were not all in place to ensure people received reliable and consistent care. The approach to planning and deploying staff did not always consider people's preferences. For example, people were not matched to their support workers, they did not receive the same workers, they were not always introduced to workers who would be working with them. Several people told us they were not contacted to tell them their calls would be late. We discussed this with the registered manager who said they were trying to make changes.
- People were provided with kind and compassionate care by support workers. People and their relatives were all very positive about the caring nature of staff. One relative said, "[Name] absolutely loves them, carers are brilliant, sometimes they sit for a while and chat" and "Staff are lovely with [Name], they are fantastic. Another relative commented, "Carers are great the Organisation is a nightmare."
- Records provided some information about people but they didn't detail what was important to the person and how they wished to be supported to provide person-centred care.

Respecting and promoting people's privacy, dignity and independence

- Most people and relative's said their privacy and dignity were respected when people were supported.
- Systems were not all in place to maintain people's privacy, dignity and independence. One relative told us, "[Name] needs two carers, the office can often only send one, they do call me and say they can send a male carer, but neither [Name] or me want this. I have complained about this but the office put the blame on me saying I said no to a male carer and that was that."
- Care plans were not in place, describing for staff how to provide individually tailored care and support, that respected people's privacy, dignity and independence, including their preference of gender of worker to support with personal care.

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

- Improvements were needed to support people to be involved in decision making. Communication care plans were not in place which documented how people communicated.
- Information was not made available in a way to promote the involvement of the person. For example, where a person's first language may not be English or where they may not communicate verbally.

This was a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

People and relatives were consulted about people's care and involved in their decisions. One person told us, "I was involved in my care plan, I spoke to the manager a long time ago." A relative said, "We were involved at the beginning with the clinical health care plan."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated 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 did not all receive person-centred care. Records did not reflect the care provided by staff. Records did not provide clear guidance to staff on how to meet people's assessed needs or to mitigate identified risks.
- People's care needs were not evaluated regularly to monitor people's well-being.
- Staff completed a daily record at each visit, for each person in order to monitor their health and well-being. We advised this information could be incorporated into a regular evaluation of care records to ensure people's needs were being accurately met.

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.

- The registered manager told us information could be made available in various formats including audio, large print or different languages to meet individual communication needs. However, this was information was not available for a person whose first language was Arabic.

End-of-life care and support

- No person was receiving end-of-life care at the time of inspection.
- Information was not available about people's religion and cultural preferences if this support was required.

Improving care quality in response to complaints or concerns

- A complaints procedure was available.
- Systems needed to be more robust to acknowledge, investigate and respond to complaints to show people they were being listened to. A more regular analysis of complaints should take place as part of quality assurance to identify themes and trends.
- The complaints log and people's comments showed recurring themes and they did not believe complaints were handled effectively. One person said, "I have complained several times to the company, [Name] needs a routine, they live with dementia" and "I have written to complain and this was only responded to by telephone, nothing in writing." Another relative commented, "Me and my relative have spoken to the office several times about care, we're now going to the social worker as not getting anywhere, no one comes back to us."

This was a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated 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.

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

- Improvements were required to aspects of care provision to ensure people were the main focus and central to the processes of care planning, assessment and delivery of care.
- Systems were not in place to ensure people received safe, timely and consistent care that respected their needs and wishes. People were not kept informed when staff were late, calls were sometimes missed, people o did not always know who would turn up on their doorstep to provide care.
- Records did not always provide information to ensure staff delivered appropriate care and support and to reflect the care provided by staff.

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

- Some systems were in place to manage the day-to-day running of the service but people fed back to us that they did not always find these to be effective or aligned to their wishes and preferences. For example, appropriate arrangements to cover staff absences and staff changes.
- Spot checks took place however these could be extended to gather more regular feedback from people and to observe staff supporting people. People's comments and complaints did not show they had been listened to in some aspects of care provision.
- Audits were completed to monitor service provision and to ensure the safety of people who used the service. The audits consisted of weekly, monthly, and quarterly checks. These audits were not all effective as they had not identified issues we found at inspection. A formal system was not in place to check that identified actions were carried out and to audit the registered manager's audits.

This was a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

- The registered manager and provider's representative were responsive and provided information after the inspection which showed how some issues were to be addressed.
- The registered manager understood the duty of candour responsibility, a set of expectations about being open and transparent when things go wrong. No incidents had met the criteria for duty of candour.

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

● Staff said they were supported. They were positive about the registered manager and management team and said they were approachable.

● People were involved in decisions about their care. They were consulted on an individual basis. However, improvements were needed to show that people were consulted and listened to with regard to their care and support requirements.

● The management team and staff were enthusiastic and keen to improve the service for the benefit of people using it. One relative told us, "There have been some problems but the new co-ordinator has settled things with regard to time keeping."

Continuous learning and improving care; Working in partnership with others

● There was a programme of ongoing staff training to ensure staff were skilled and competent.

● Records showed that staff communicated effectively with a range of health professionals to ensure that the person's needs were considered and understood so that they could access the support they needed.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not all in place to mitigate risk and to ensure people received safe care and treatment. Regulation 12(1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected from the risk of inappropriate care and treatment as records and robust systems were not in all place to monitor the quality of care provided. Regulation 17(1)