Springfield Home Care Services Limited

North Yorkshire Care

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 24 August 2016 and was announced. At the last inspection in August 2014 the service was found to be meeting the Regulations assessed.
North Yorkshire Care is operated by Springfield Homecare Services Ltd. They provide a domiciliary care agency that supplies personal care, support and domestic services to people living in their own homes in Knaresborough, Harrogate, Wetherby, Boroughbridge and Ripon. The majority of people who use the service are referred to the agency by North Yorkshire County Council. The care packages delivered range from 15 minutes to block packages which are up to 12 hours a day.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager had good oversight of the service and was experienced in their role. We found that quality monitoring systems were not always effective at identifying safety issues or areas for improvement. Records of accidents and incidents did not always reflect the action taken. This was identified as a breach in the Regulations and you can see what action we have told the registered provider to take in the main report.

Staff were confident about how to protect people from harm and what they would do if they had any safeguarding concerns. There were good systems in place to make sure that people were supported to take medicines safely and as prescribed.

Risks to people had been assessed and plans put in place to keep risks to a minimum. An 'out of hours' service was in place so that people could contact a member of staff in an emergency.

There were enough staff available to make sure people's needs were met. The registered provider had robust recruitment procedures to make sure staff had the required skills and were of suitable character and background.

People were cared for by an enthusiastic and caring staff group. Staff were supported through training, regular supervisions and team meetings to help them carry out their roles effectively. There was an open and accessible management team.

The manager and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). A decision to deprive a person of their liberty in a domestic setting must be legally authorised by the Court of Protection. The registered manager told us that no one was currently subject to any restrictions by the Court of Protection.

People told us that staff were caring and that their privacy and dignity were respected. Care plans were person centred and showed that individual preferences were taken into account. Care plans gave clear directions to staff about the support people required to have their needs met. People were supported to maintain their health and had access health services if needed.

People received support which was regularly reviewed and met their current needs. People knew how to complain and had opportunities to make comments about the service and how it could be improved.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There was safe management of medicines which meant people were protected against the associated risks.

Staff were confident of using safeguarding procedures in order to protect people from harm.

Risks to people had been assessed and plans put in place to keep risks to a minimum.

There were sufficient numbers of staff to meet people's needs. Recruitment procedures made sure that staff were of suitable character and background.

Is the service effective?

Good

The service was effective.

People who used the service were supported by staff who had the knowledge and skills necessary to carry out their roles effectively.

Staff understood the requirements of the Mental Capacity Act 2005 and relevant legislative requirements were followed.

People were supported to maintain good health and were supported to access relevant services such as a GP or other professionals as needed.

Is the service caring?

Good

The service was caring.

People told us that they were looked after by caring staff.

People, and their relatives if necessary, were involved in making decisions about their care and treatment.

People were treated with dignity and respect whilst being supported with personal care.

Is the service responsive?

Good

The service was responsive.

People received personalised care. Care and support plans were up to date, regularly reviewed and reflected people's current needs and preferences.

People knew how to make a complaint or compliment about the service. There were opportunities for people to feed back their views about the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The systems in place to look at the quality of the service provided were not fully effective at identifying shortfalls in order to improve practice. The CQC had not always been notified about serious incidents, as required.

The service had an experienced, registered manager in place.

There was a caring culture at the service.

North Yorkshire Care

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 registered provider is 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.

This inspection took place on 24 August 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection was carried out by two inspectors.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We also looked at previous inspection reports. We reviewed the Provider Information Record (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we visited the office and looked at records which related to people's individual care. We looked at nine people's care planning documentation and other records associated with running a community care service. This included five recruitment records, complaints, notifications and records of meetings. We spoke with the registered manager, the manager for another service, a care co-ordinator, care supervisor and two care staff.

After the inspection we spoke over the phone with six care staff, eight people who received a service and one relative. We also received feedback from North Yorkshire County Council Quality Monitoring Team.

Good

Is the service safe?

Our findings

The people we spoke with raised no concerns about their safety. Staff were confident about identifying and responding to any concerns about people's well-being. Staff had received appropriate training in this area to support their understanding of safeguarding. One member of staff said "All safety documentation is in place. My safeguarding training up to date" and another told us "I always report the littlest things to keep people safe". Staff had an understanding of whistleblowing procedures should they have any concerns about practice within the organisation.

We looked at records of accidents and incidents and identified two recorded serious incidents which had not been raised as safeguarding concerns. We received an explanation from the registered provider for one of these incidents and concluded that there had been a lapse in recording. However, one serious incident had not been reported to the CQC after the registered provider had been made aware of it. We noted that other health and social care services had been involved and the provider had taken remedial action which included updating policy and changing practice to keep people safe. The registered provider had notified the CQC as required, since the incident occurred.

Each person had risk assessments in their care records which covered areas such as the environment, falls, nutrition and personal care. Health and safety risk assessments and manual handling risk assessments were also in place. Each risk was identified and any action needed to reduce risk was recorded. Risk assessments were up to date, clearly written and understandable.

One person had a local authority care assessment which showed they were at an increased risk of self-neglect, and could be a potential risk to themselves and other people. Records showed that on one occasion they had fallen. However, the risk assessment did not reflect that the fall had occurred or that there was an increased risk of falls due to changing needs. We discussed this with the registered manager who completed a risk assessment straight away.

Medicines were managed safely. Some people who used the service were unable to take their own medicines safely and relied on staff to make sure they took their medicines as prescribed. This is called medicine administration. Each person who needed their medicine to be administered by staff had a Medication Administration Record (MAR). Some people had their medicines prepared in 'blister packs' by a pharmacist in addition to other boxed medicines and creams.

The MAR that we looked at were clearly recorded and matched the information in care plans. There were no unexplained gaps in recording. MAR included details of any allergies as well as contact details for the doctor should any problems arise. Each person had a medicine assessment in their care record which, as well as giving details of medication, included information about who orders and collects. Staff were trained and assessed as being competent, before being able to administer medicines. We identified no concerns with medicines management from the feedback we received.

Staff files demonstrated that the registered provider operated a safe and effective recruitment system. The

staff recruitment process included completion of an application form, a formal interview, previous employer references and a Disclosure and Barring Service check [DBS] which was carried out before staff started work at the service. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working in the care sector.

We discussed areas where the service might improve their recruitment practice by recording the date of original documents when seen, recording the name of interviewers, and recording DBS serial numbers.

We identified no particular issues regarding the timing of calls or missed visits. The service operated a half hour leeway on call times, which was explained to people when they started. People told us that calls were mostly on time and that they usually had the same care staff who they were familiar with. One person said, "They come on time. If they are a bit late there is a good reason" and another commented, "Staff turn up on time. They ring up if they are going to be late. I have the same group of staff". One person felt that, "They don't always keep to a regular time" and added "Some tell me beforehand if they are going to be late but not always".

Staff were issued with uniforms and personal alarms, together with the employee handbook and code of conduct. Newly appointed staff completed a five day induction comprising safeguarding, health and safety, food safety, infection control, medicines and first aid. New staff worked with more experienced staff and were required to be signed off as competent before being allowed to work alone unsupervised. This helped to ensure that staff worked in a safe manner regarding reducing any risk.

The service operated an 'on call' system from 5pm in the evening giving staff access to management support. Care workers were encouraged to text the 'on call' staff to confirm they were home safely when working at night.

Good

Is the service effective?

Our findings

Staff told us that they enjoyed their work and felt supported to provide an effective service. Comments included, "It's a pleasure to get up and go to work", "I have always enjoyed it. It fits in with my lifestyle. I feel supported" and "I love the job". People said to us that they were happy with the care staff who supported them. One person said, "I get a regular morning carer who is absolutely wonderful" and another told us, "I am happy with the carers. They are pretty good".

We spoke with the member of staff with responsibility for staff training. They explained that the organisation's training department contacted them on a regular basis, which meant they could 'flag up' any areas of training required. Examples included dementia and palliative care. Training plans were updated monthly and training letters were sent out to staff who needed refresher training. They said that the frequency of training was kept under review meaning that they were able to increase this as required. For example, we saw that following a recent decision safeguarding training had been increased to annually. The care supervisor reported good relationships with the local community nursing service and they said nurses had delivered training on pressure area care and stoma care. They also provided student nurses with the opportunity to shadow care workers to enhance shared learning.

Staff made positive comments about the training they received. Feedback included, "Training has always been kept up to date", "I have so much training. I'm impressed with it" and "All my mandatory training is up to date. We are able to do additional training if we want". One member of staff described how they were trained in moving and handling which was a practical, hands on course. They added that they were also trained in the proper use of equipment, such as hoists.

Records showed that new staff were supported to complete the Care Certificate. This is a set of standards for social care and health workers, which covers minimum standards that should be part of induction training of new care workers. The care supervisor said that ongoing training and staff support was offered through spot checks every three months, planned observations and annual appraisals in addition to one to one meetings or supervision. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. We saw records to confirm that supervision, observations and annual appraisals had taken place. This showed us that staff training needs were kept under review so that they were aware of their roles and responsibilities and had the skills, knowledge and experience to support people who used the service.

Staff received a rota each week which showed their call schedule. The care staff we spoke with told us said that they usually worked in the same geographical area and that, on the whole, they were provided with sufficient time to travel to calls. One staff member said, "There is enough travel time" and another commented, "The timings are achievable. I tend to work in the same area. It's manageable". The service operated an 'on call' system from 5pm in the evening giving staff access to management support if needed.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care settings is called the Deprivation of Liberty Safeguards (DoLS) and can be legally authorised by the local authority. However, this is not relevant for people who receive domiciliary care in their own homes. This means any decision to deprive a person of their liberty in a domestic setting must be legally authorised by the Court of Protection. The registered manager told us that no one was currently subject to any restrictions by the Court of Protection.

We checked whether the service was working within the principles of the MCA. Staff understood the Mental Capacity Act 2005 (MCA) and the importance of gaining consent from people for them to provide care and support. Although there was no specific training on the MCA, issues of consent were included in training on safeguarding and dignity and respect. A training bulletin was recently sent to all staff and included information regarding the MCA and the Code of Practice. One staff member confirmed, "People are assessed for capacity under MCA and I have a good understanding of this".

We found that care plans contained good information about how each person made decisions and choices. The focus was on what people were able to do for themselves. Records frequently prompted staff to check with people to make sure they were aware of what was happening and were consenting to the care and support provided.

Where required there was information in people's support plans about people's needs in relation to eating and drinking. For example, where people needed a special diet or had particular preferences. The registered manager told us that most food preparation consisted of warming up 'microwave meals' or food that family had prepared earlier which required heating. They also made sure that they checked people's fridges, with their permission, and made sure food was in 'date order' and they removed any 'out of date' food.

People were supported to maintain their health and had access to health services as needed. Support plans contained clear information about peoples' health needs. There was evidence of the involvement of healthcare professionals such as a GP or hospital. The service had good links with the local community nursing service. People living with dementia received support through specialist teams and had access to a social worker as needed. They also provided student nurses with the opportunity to shadow care workers to enhance shared learning.

Good

Is the service caring?

Our findings

We received positive comments from people about the care and support they received. These included, "It's good. I'm happy with it", "I like it very much. I have two very good carers. They are caring and kindly" and "I find it a lot easier when carers come to help me. They are kind and helpful". The staff we spoke with demonstrated a caring attitude to their work. One member of staff told us, "I love the job. I'm a caring person" and another said, "I think we provide very good care". All the staff we spoke with were positive and enthusiastic about providing a caring service.

People told us they were treated with respect and dignity. One person told us, "They [staff] are respectful when they visit the house" and another person commented, "I am happy with the carers. They are kind and respectful".

We looked at how the service promoted dignity and respect. The registered manager told us that this was discussed on the first day of induction for new staff as it was an important aspect of their work. Staff confirmed that they had received training which included dignity, respect and choice. We noted that in the training room there was a display on the wall about the core principles to support dignity. People's care plans were also written in a way which emphasised respect and dignity whilst carrying out care tasks.

Staff were able to describe the importance of promoting dignity and respect. One staff member explained, "We are always taught to maintain dignity, such as putting a towel over someone during personal care". This was made clear upon in the Statement of Purpose for the service, which described in detail how they would, "Strive to preserve and maintain the dignity, individuality and privacy of all customers".

The Statement of Purpose emphasised the importance of encouraging choice and involvement for people who received a service. This included the right to choose how tasks should be carried out by care staff and the right to make choices about everyday routines such as food and clothing. We found that this was reflected in people's care plans, which held clear information about how people wanted to be involved with their support as well as any choices and preferences they had communicated to the service. We noted the response one person had made on a feedback survey form in August 2016 which stated "I am always offered choice".

People told us that they were involved in reviews and meetings and that, if required, a relative could also attend for support. The people we spoke with all said they could contact the office easily and that there was an emergency contact number for when the office was closed. Feedback confirmed that people felt listened to when contacting the office and that any issues were usually dealt with promptly.

Good

Is the service responsive?

Our findings

Records showed that a supervisor or care co-ordinator had visited people before a service was provided in order to carry out an assessment of their needs. Each person had a care plan which detailed their assessed needs and how they were to be met by the service. Support plans were focussed on individual needs and included likes, dislikes and preferences for care and support. There was a clear description of each person's current situation and their needs in relation to areas such as communication, mobility and mental health.

The care plans gave clear guidance for care staff on how to provide individualised care and support. This included information about what the person could do for themselves and how to support them in the way they preferred. Guidance included information about where to locate items in the person's home, what colour flannel or towel to use when having a wash and reminders to check with people that they were comfortable. Where people had a particular preference this was included in the plan. For example, one person's plan stated, "I will inform carers each call what chair I choose to be in".

Each care task was broken down in to small steps. For example, the guidance to support one person with putting on their socks stated, "Apply cotton wool in between toes and apply socks, ensuring that you turn the tops down to avoid digging in skin". This meant that care staff were provided with clear information about how to support people in the way they preferred. The level of detail also promoted a consistent approach to care as all staff had clear guidance when providing support. This was confirmed by one person who told us, "They remember things the way I like them. They know how things should be". Another person commented, "There was a new member of staff who looked through the folder [care plan]. I didn't have to tell them much".

Care plans were up to date and reviewed as necessary. People told us that when reviews took place they were involved in the discussion. One person commented, "I had a review recently where we were reminded about times". Staff members told us that support plans contained sufficient detail and were generally kept up to date. One member of staff told us that sometimes information could be lacking when people were discharged from hospital and needed urgent support from the service. However, the staff we spoke with told us that if they were not sure about anything they would contact the office for further guidance. We were told that a senior was always available if needed. After providing care and support care staff recorded a summary of the visit in a daily log. We looked at a sample of logs and these showed that care was given in line with care plans.

People were provided with guidance on how to make a complaint if needed. There was clear information provided to people about how to make a complaint. This included contact details for relevant local authorities and the CQC. People told us that if they had any concerns they would contact the office. Comments included, "I tell them if I have any complaints" and "I get in touch with the office if needed. They sort the problem out". In a survey carried out in July 2016, 97% of 76 respondents said that they knew how to make a complaint. We noted that when people started using the service they were asked to sign a customer agreement which included an acknowledgment that they had been informed about the complaints process.

A log of complaints was kept in the office. Although there had been no recent complaints recorded we noted that previous complaints included a clear record of the action taken in response.

Requires Improvement

Is the service well-led?

Our findings

The current registered manager spoke knowledgeably about the service and had a clear understanding of the requirements and responsibilities of their role. They were passionate about providing personalised and responsive care and support. The registered manager was aware of new developments and legislation in adult social care. For example, they had started to prepare for the Accessible Information Standard, which places a duty on adult social care services to provide information to people in the way they prefer.

Although there were systems in place to monitor areas of practice and assess quality, these were not always effective at making sure procedures were followed. We identified two recorded serious incidents which had not been raised as safeguarding concerns. We received an explanation from the provider for one of these incidents and concluded that there had been a lapse in recording. However, one serious incident had not been reported to the CQC after the registered provider had been made aware of it. The issues regarding this incident are currently being investigated by the local authority safeguarding team.

We found that accidents and incidents were recorded individually in people's notes, but there was no overview or summary in place for management to monitor and review the level of incidents. This meant that changes in people's needs and related risks may not be identified promptly to keep people safe and to ensure that improvements were made when required.

Although we did not receive any particular concerns about the timing of calls, there was no management system in place to monitor call timings as part of a quality audit. However, without a system in place the registered provider could not assure themselves that calls were on time. When asked the registered manager said the provider had felt the system of 'call monitoring' was not cost effective so had ceased using it. The registered manager accepted that recording and monitoring was an area that required improvement. They added that a new quality assurance manager was now in place in the organisation and that this would make a difference.

These shortfalls meant that the quality and safety of the service was not being monitored effectively. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to directly assess the quality of care being provided by staff. Senior staff carried out 'spot checks' on care staff whilst they were out on a call. These observations were recorded and discussed with the member of staff concerned. Staff confirmed these took place regularly.

There were regular team meetings which staff told us took place every one or two months. The last meeting was at the beginning of August 2016. These meeting gave all staff an opportunity to meet with management, share experiences and ideas and get up to date information about work practices. The registered manager told us that they also sent out regular memo updates to staff with current information and updates. The last memo in August 2016 included an update about training, record keeping, dignity in care and diary sheet recording.

Care staff told us that there was effective management of the service. One member of staff said, "Management have an open door policy. They are very approachable. They take issues on board. Open to suggestions. I have a good relationship with the management team. We work well together". Other staff comments included, "Since the new management team there have been changes for the better" and "I think the managers are very good and listen". One staff member felt that there had been a recent reduction in management support due to a focus on developing a new service elsewhere. However, this was not raised as an issue by other staff.

There was a positive, caring culture at the service. Staff demonstrated a commitment to provide person centred care in line with the ethos of the service. There was clear information about the aims and objectives in the Statement of Purpose. Staff were aware of the expectations of the provider and, when asked, were able to describe the ethos. One member of staff confirmed, "The main aim of the service is to maintain dignity and independence".

The registered provider sought feedback from people who used the service and their relatives to help assess the quality of the service. Feedback surveys were sent out to people throughout the year. We saw a sample of those that had been returned in recently. They were generally very positive about the service received. Some people had made comments about timing and lateness although it was unclear if any action had been taken in response. The registered manager said that once all the survey forms had been received, a branch meeting would be held to go over the responses and identify what was going well and what areas needed further development in the service. The registered provider maintained contact with other professionals such as social workers and district nurses in order to promote and review good practice.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not always effective at assessing, monitoring and mitigating the risks relating to the health and safety of people who used the service. Regulation 17(1)(2).