Phoenix Homecare (Norfolk) Ltd

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Inspection report

6a London Street
Swaffham
Norfolk
PE37 7DG

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23 December 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place over two dates and was unannounced. On the 19 December 2016 we visited the registered office, met with some of the staff and viewed the paperwork, including care plans, staff files and other records relating to the management and running of the business. On the 23 December we accompanied a carer to visit some people who used the service. We also contacted a number of people, their relatives and staff to ask them about their experience of the care provided by the service.

The service provided domiciliary care and at the time of our visit was supporting approximately 87 people with a range of different support packages including domestic support, help with personal care and overnight sits.

The service had two registered managers 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 service was well managed with two registered managers both overseeing different areas. Together they formed an established team who knew their business well. They had worked within the care profession for many years and had extensive knowledge of the resources in the area and professional contacts. There were enough staff to deliver the care at the time they it was needed.

The feedback we received about the service was good. People using the service understood the role of the service and were positive about the care that they received and the management team. People knew how to contact the office and told us that they were kept informed if for any reason there was a change in the staff member providing their care or if staff were running late. People told us they had not had any missed calls and the agency provided a reliable service. People benefited from being supported by regular staff with whom they had established a strong bond and who were familiar with their needs.

Care plans were implemented quickly following an assessment of a person's needs. Staff were familiar with people's needs and referred to care plans to help inform their care practices. People told us care plans were not reviewed regularly and there was some discrepancy in how often they should be reviewed.

The agency had robust staff selection and recruitment procedures in place to help ensure only suitable staff were employed. Staff received excellent training and a thorough initial induction to help ensure they had the right competencies and skills to fulfil their role. The service also provided on going opportunities for staff to further develop their knowledge and skills. However, staff were not provided with regular formal supervision sessions and we were not assured that there were adequate systems in place to monitor staff competencies and practice

Some people required staff to administer their medication, whilst other people were able to take their own

medication with staff prompting them when required. Training was given to staff and staff were observed by senior staff to ensure they were competent to undertake this task. However, we found that the auditing of medication records could be improved upon. We also had concerns about the processes that were in place to support a person who took their own medicines but were not consistently able to so reliably.

Staff knew how to safeguard people and protect them from abuse. Systems were in place to assess and manage potential risks to people. However, risk assessments needed to be more robust and the service were not adequately protecting people's personal information. There were also systems in place to ensure risks were adequately managed. Risk assessments could be more robust. The service was not adequately protecting people's personal information.

People gave their consent before care and treatment was provided. Staff had been provided with training in the Mental Capacity Act (MCA) 2015 and Deprivation of Liberty Safeguards (DoLS). People were supported in line with the legislation of the MCA and no unnecessarily restrictive practices were in place. The MCA and DoLS ensure that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process.

People were encouraged to eat and drink and staff kept detailed records showing how people's needs were being met. These provided evidence that staff were acting upon concerns and changes to people's health and ensured that people received timely medical intervention as needed.

The service took into account feedback from people to shape and improve the service. The service was responsive to people's needs and communication was described as excellent by staff and people using the service.

Staff were caring and helped facilitate people's independence and promote their well-being. Care was provided in a respectful, consultative way.

The service was well- managed which enabled it to provide effective care that was flexible and reliable. Staff felt well supported however, the systems in place to support staff needed further review.

The service had systems in place to monitor the service it provided and respond to feedback about the service.

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 as safe as it could be.

Medicines were administered by trained staff. However, medication audits and care plan reviews did not clearly identify when a person was no longer able to take their own medicines reliably..

Potential risks to people had been assessed, however they were not always detailed enough.

People's personal data was not adequately protected.

There were enough staff to meet people's needs and the service provided effective and reliable support.

Staff recruitment processes were robust.

Staff understood their responsibility in terms of safeguarding people

Is the service effective?

Good

The service was effective.

A robust induction programme was in place and staff were adequately supported through excellent training opportunities. However, staff did not receive regular formal supervision.

People's health care needs were being met. This was demonstrated through records which showed good monitoring of needs.

Staff encouraged people to eat and drink according to their needs and reported any concerns to other health care agencies where relevant.

Staff provided care and treatment in consultation with people and where available family members. Consent for care was always sought.

Is the service caring?

Good

The service was caring.

Staff promoted people's health and well-being. Staff provided a service which was responsive to people's needs and promoted their independence and autonomy.

The service communicated effectively with people and involved them in the assessment, planning and review of their care

Is the service responsive?

Good

The service was responsive.

Care plans were put in place following an assessment of need.

People's needs were met consistently by well trained staff who were familiar with their needs. Staff recognised changes in people's needs and were flexible in their approach. However, care plans were not consistently reviewed on a regular basis..

The service responded to feedback about the service and had an effective complaints procedure.

Is the service well-led?

Good

The service was well led.

The managers were knowledgeable and supportive of people using the service and their staff.

.The management team communicated well with staff and effective management systems were in place to support and develop the service.

The management team worked well with other agencies and families to ensure people's needs were fully met.

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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 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 the 19 and 23 December 2016 and on the first day of the inspection was unannounced. We announced the date of the second day of the inspection to give the provider time to gain consent from people using the service for us to visit them in their own homes. The inspection was undertaken by one inspector.

As part of this inspection we looked at previous inspections and notifications which are important events the provider is required to tell us about. We received a provider information return. This 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. As part of this inspection we visited three people using the service and spoke with a further four. We met one relative and spoke with a further three. We spoke with four care staff, one of the registered managers, the team manager, the training officer, a care coordinator, and the finance officer. We looked at staff records, six care plans and people's records. In addition we looked at other records relating to the management and running of the business.

Requires Improvement

Is the service safe?

Our findings

People mostly received their medicines as intended. People told us staff supported them with medication including eye drops and the administration of creams, whilst other people required staff to prompt them or check that they had taken their medication. However we found records did not always identify risks around medication administration. Records did not always identify if a person was continuing to take their medicines safely or how potential risks were being mitigated. We observed staff supporting some people with their medicines, and this was done appropriately. However for another person the person was unclear as to what they were taking and when they should be taking it. Care staff were writing in their daily notes when the person had been observed taking their medicines but this did not show all their medicines were being taken as required. The person had an infection which might have made them more muddled than usual, but staff had not recorded this in their daily notes. A risk assessment was not in place to show what actions staff had taken to protect the person.

We looked at people's records and saw some people required assistance with their medication. Medication was administered by trained staff from the original packaging at the required time. Records were kept of what was being administered and medication records were periodically checked by office staff. Staff received comprehensive medication training and there was an assessment of their competencies. Where people were assisted with medication there was information in their care plans as to what medication they were taking and any known risks, such as if the medicines needed to be locked away for the persons own safety. Senior staff told us they would only administer medication according to the prescription. Any changes in medication had to be actioned through written instruction not verbal instruction. Some people had been prescribed pain patches. We saw guidance in their care plans for staff around rotating the patch to reduce skin irritation. Senior staff told us staff would be called in for supervision if gaps in people's medication records were identified. Medication records were transferred to the office on a monthly basis to be checked. This system was under review to ensure that the process of was more thorough and happening more frequently.

Staff knew how to safeguard people in their care and how to raise any concerns they might have about a person in relation to their health and safety. Staff received training in safeguarding adults from abuse. They knew how to recognise, respond and report potential or actual abuse. The service supported staff through training and key policies and procedures on safeguarding and whistle blowing were available for staff to refer to. The manager had completed enhanced safeguarding training for managers which included guidance about how to carry out initial investigations. Only one recent safeguarding concern had been raised by the service and they were in the process of dealing with this appropriately. One family member told us about some concerns they had raised. They said that the manager had dealt with the situation appropriately and had kept detailed contemporaneous notes so they could respond accordingly.

Risks to people's safety were documented and mitigated to a large extent because staff were aware of people's needs and able to quickly recognise changes to people's needs. However we found documentation would benefit from more detailed information at the point of assessment. People's records contained an environmental risk assessment but this was a basic tick list with very little detail on it and not all the forms

were complete. For example staff member had ticked to say if people had working smoke detectors but we could not ascertain how they had established this or who was responsible for checking the batteries. The same risk assessment identified whether a person smoked or not but where this was ticked there was no additional information or evidence of increased risk. We noted access to some people's property was either via a key safe or a back door and found the latter an unsafe practice. We carried out a number of visits and found some properties in isolated spots with no outside light posing a risk to care staff and not identified as part of the risk assessment.

Accidents and incidents were recorded and monitored to see if actions taken were suitable or if more could be put in place to improve the service and reduce risk.

We also found that the security of how people's personal information was stored was not always adequate. Staff accessed some people's properties through the use of key codes. This information was recorded along with a person's name and address on paper rotas which staff were required to bring into the office for shredding. However this posed a potential risk if the rotas were lost or mislaid. Staff were sometimes required to handle people's monies. The service had a financial policy in place which provided guidelines for staff to follow regarding this. The manager told us that staff used cash transaction sheets to record monies taken, returned and any evidence of any purchases made on behalf of the person. However, the transaction sheets were only audited when the sheet was full and transferred to the office. This meant that there was the potential problems to go unnoticed for some time before they were brought to the attention of the manager.

Staff had training in manual handling which was kept up to date. Staff were also shown how to use specific equipment in people's homes. Manual handling risk assessments and guidance were very detailed and in place as required.

The service had enough staff to deliver the care and had additional administrative and management staff that could cover care calls if required. People confirmed they had continuity of care. One person said, "I have the same two carers mainly. They are reliable and come the same sort of time every day." A relative told us, "Staff always provide extra back up if we are away." Staff told us they had enough time to meet people's needs and that travel time was minimal because the rotas were planned with care and consideration of where people and staff lived to minimise travel time between calls.. . Staff said if people required more care this could be provided and needs would be reassessed to establish how much support they required. Care calls were planned around the times required with a half an hour window either side of the call. Staff were paid for travel time and there was no evidence of missed calls. The rotas were planned in advance and took into account staff training and planned holidays so that vacant shifts were known in advance and could be planned for.

There was an effective on call system in place to ensure calls were covered, emergencies were responded to and staff were adequately supported.

We reviewed staff files and saw that staff were recruited to post after the appropriate checks had been completed. The purpose of these checks was to ensure the person was suitable to work in care. Checks included a work history, proof of identification and address, health status, references and a disclosure and barring check (DBS). A DBS check would show if someone had any criminal convictions or had ever been barred from working with vulnerable people. Once these were in place and subject to a satisfactory interview and probationary period staff were given a permanent contract.

Good

Is the service effective?

Our findings

People needs were met by adequately trained staff. One person told us, "They are good at whatever they do"A relative said, "Good communication and I am confident with the skills of the staff. They receive excellent training." Feedback from staff about the service was positive. All the staff we spoke with told us that they felt adequately supported and that the service provided a good standard of care to people.

The service was supported by a number of managers, administration staff and care co-ordinators. A training officer was employed two to three days a week. They explained to us how they inducted new staff into the service to ensure that they had the necessary competencies and skills to fulfil their roles. During the induction week new staff would cover essential training needed, including manual handling and infection control, before providing care to people in their homes. They also covered key policies and procedures so they knew what was expected of them in the work place. These were summarised in the staff handbook. New staff completed a minimum of 21 hours of shadow shifts. This involved them going out with a more senior member of staff, being introduced to the person they would be caring for and being shown how the person liked to be supported. During this period of shadowing the staff member supervising the new member of staff would record initial observations of their performance to help decide when the staff member was confident and skilled enough to work on their own. Prior to starting their office based induction staff would complete an initial observation shift to give them a deeper understanding of what the work entailed and help them decide if they wanted to go ahead with their employment.

Staff new to care were required to complete the care certificate, a nationally recognised set of induction standards relevant to staff working in the care sector. Where staff appointed already had experience and, or qualifications in care, the service sought verification of this.

The registered managers, training officer and team manager had experience and qualifications in care relevant to their role, including training in staff management and assessor training for the Care Certificate. They provided strong leadership and direction for staff. We saw a lot of training materials and information was available to care staff. Staff confirmed they had all the training they required and this was kept up to date. Staff described training as very good. We looked at training and development opportunities for staff and saw that training was provided both in house and through external sources including the local councils. Individual staff training records did not show us that staff training was up to date but a centralised matrix showed us when training was initially provided and when it required an update.

Training around people's specialist needs was provided where required such as palliative care; stoke management, and dementia care. Some of the people supported by staff were living with dementia. The service reported that they had experienced poor access to mental health services but had worked alongside voluntary organisations. They had organised dementia training for some but not all of the staff. One staff member had completed a dementia care coaching course so they could support staff with any issues they might have. The training officer told us currently they had 4 to 5 staff completing additional care qualifications with a further 6 already holding a qualification.

Staff supervision took place but there was an over reliance on staff raising issues as they occurred rather than regular supervisions taking place. Staff told us they did not receive many formal supervision sessions but felt the support provided to them was good and managers and senior staff were very approachable. A senior member of staff told us supervisions occurred every six months one of which included a direct observation of practice. The manager said they would like to do this quarterly. Records showed that staff had not been receiving annual appraisals. We saw that a plan was in place for an appraisal system to be reintroduced to the service.

The manager told us that staff meetings were held approximately three times a year however records showed that the last one had been held nine months ago. A newsletter was circulated to the staff advising them of any important changes and information they needed to be aware of. We saw where there had been concerns about staff's performance and conduct, additional supervisions were held showing how concerns were being addressed in line with company policy.

Staff had completed training in respect to the Mental Capacity Act 2015 and understood their responsibilities to ensure people were given choices about how they received their care. Staff knew to establish a person's consent before supporting a person with their care needs or treatment. Care plans showed people had consented to their care and had been involved in the original assessment and implementation of their care plan. Consent was recorded. Where a person needed support around decision making the agency involved others such as family members and health care professionals.

In terms of people's nutrition staff confirmed they did not routinely weigh people or use food and fluid charts. However, care plans indicated if a person needed encouragement to eat and drink and staff documented in people's care records when the person was offered and had taken a drink and, or a snack. We observed staff encouraging people to eat and offering them a drink with their meal. Where a person refused in one instance, staff asked if they could prepare something for the person to have later to which they agreed. They left ensuring the person had already had a drink and had one for later. The person confirmed to us that they were reluctant to drink because of getting up to the toilet but said staff always encouraged them.

People's health care needs were met. Consistent staff teams enabled staff to become familiar with people's needs and report any changes. All staff were knowledgeable about when they should be reporting concerns and the daily notes provided a good account of the support provided. Staff said they referred any changes of people's needs either to the manager or if urgent directly to the GP or District nurses and that they worked with other health care professionals as and when required. We spoke with staff who provided urgent care/ night care and they had relevant experience and confidence to fulfil their roles. They were able to tell us about the training they had received to enable them to respond to specific health care needs and any changes in the persons health care, particularly in relation to end of life care

Good

Is the service caring?

Our findings

People using the service spoke positively about the care that they received. One said, "Brilliant agency, every one of them have been just brilliant." They told us they had two main carers but all of them were okay. They told us they spend the time they were meant to and sat and chatted. Another said, "Lovely people, they do what they say they are going to do on the tin." They went on to say, "I look forwards to them coming, they are all like friends and get on well, you can have a laugh with them." Another said, "The carers are very personable and don't poke around."

Through our observations of care provided to people it was clear that one of the most positive aspects of this service was that they allocated specific carers to people and where people had multiple visits they allocated small teams. This enhanced people's quality of care because staff were familiar with people's care needs and what they needed help with. Staff got to know people and their families well and it became apparent when talking to people that they looked forward to the staff visits and felt sad when staff left. A recent bereavement had left people the staff supported very upset. The bond between staff and people using the service was strong and everyone we spoke with said the carers were kind. People told us the only time staff were late was because they had to stay with a person when they were ill or required medical attention. They said that they did not feel that this was a problem as they would hope staff would do the same to them. One staff member told us, "We pull together if someone was ill to ensure people were appropriately supported."

People told us staff showed respect towards them and this was confirmed by the findings of the quality assurance survey completed by the service. One relative told us how the agency supported their mother which enabled them to stay in their own home and continue to do the things they were able to do by themselves. This person was over 100. We spoke to another person who described how carers kept them going and provided support according to their variable needs.

We met a person whose relative had gone into hospital. They explained that staff had arranged this and had stayed with them to provide support and comfort. They said, "Staff are lovely and kind. " Other people supported by the service told us how staff responded to emerging situations and were patient and kind in times of ill health and distress. This was very much appreciated and something family member commented on saying they could rely on the service to keep them informed and respond accordingly.

People were consulted about their care and we saw they were involved in the assessment and planning of how they wished their care to be delivered. Family members told us that the service communicated effectively with them about any amendments to the care being provided and any changes to their family member's needs. This helped them retain some control and continue to be involved in their family members care.

Good

Is the service responsive?

Our findings

Staff working at the service had a good understanding of people's needs. It was clear they listened to people and adjusted the service accordingly. Staff told us they had regular rounds and this meant they were familiar with people's needs and any changes were communicated in advance. People told us the care provided to them met their needs. One person told us, "They help me with personal care, housework and always ask me if I need anything else doing, they stay until needed and always ask me how I am." One relative told us, "Staff go above and beyond what's expected of them, I can't fault them. " They went on to tell us that the agency contacted them if there were any concerns and had acted appropriately in emergency situations.

People had an assessment of their needs before a service was provided to them. The only exception to this was when the agency provided care in an emergency situation and the person had not been known to Social Services. In these instances the information available to the service was very brief. Staff spoken with said they were always provided with some information and this was usually sufficient.

Staff also told us that care plans were put into place quickly for people receiving permanent care packages and that they had time to read them. The manager confirmed upon referral they would carry out an initial assessment which formed the basis of the care plan. This was left in the person's home, and an electronic record was also kept. The manager told us that care plans were put together following consultation with the person and, where appropriate, their relatives. They would then review records annually or more often if required. Staff told us if they raised any concerns about changes to people's needs senior staff would pop in and review their care plans and that although the service did not strictly follow an annual review process any concerns brought to the managers attention were followed up. One member of staff told us reviews took place six monthly and might be face to face or via the telephone. A number of people and relatives told us reviews were not frequent and they did not think these were done annually. We asked staff how they were made aware of changes in people's needs and they told us they relied on the staff to keep them informed and they reviewed people's daily notes which were brought back into the office at the end of the month.

The care plans contained all the essential information care staff needed to know but lacked detailed information for staff about how people wished to receive their care. Care plans described tasks such as, 'needs help with washing and dressing' without providing any detail about the persons preferences and what they could do for themselves and what they found difficult.

People received continuity of service. Rotas were issued to people so they knew which staff were visiting them to deliver their care. In the main people had regular carers for their visits but some changes were inevitable at the weekend and when their main carers were on holiday or sick. Changes were planned for and communicated to people in advance where possible to minimise any distress this might cause. People confirmed the agency kept them informed of changes and if staff were running late.

The manager told us there was an established complaints procedure and this was available to everyone and was included in the service user guide. They had no recorded complaints but did have feedback of a positive nature. Everyone we spoke with knew who in the service to contact in an emergency or to raise a concern

and all were confident that they would be listened to and responded to.

Good

Is the service well-led?

Our findings

Staff told us the managers were accessible seven days a week, either in the office or always at the end of a telephone. Staff were very complimentary about the service. One staff said, "The manager is the back bone of the company, it's a lovely company and we all get on well." Another said, "I got a job here because I heard it had a good reputation locally." Senior staff said the service operated at a grass roots level with all the staff having a good knowledge base and understanding of the needs people they were supporting. Seniors said they all knew each other's roles, which meant that they could cover for each other when required. The managers went out with staff and assisted with the delivery of care which they felt enabled them to see how staff were performing and if people were receiving the care they needed. The manager told us and staff confirmed that a lot of their work came from word of mouth due to the good relationships they had built up.

The service had a quality assurance system in which they actively sought people's views and took these into account with the future direction and development of the service. We saw that the last one was completed in July 2016. Thirty one people using the service were selected at random and sent questionnaires. People were advised they could receive the documentation in an alternative format if needed. The service received 21 forms back, a 67.75% response rate. The results were mostly positive particularly around the actual care that people received and the staff that provided it. Feedback from professionals and staff was not sought in the same way and might enhance the quality of information received if sought in the future.

The manager was fully aware of gaps in service provision and had a plan in place to address this. . This included gaps in medication recording. In response to this they had identified named staff who would be paid a slightly enhanced rate for checking and reporting on the medication records in people's homes each week. This would mean gaps in signatures would be identified sooner and staff could be identified and supported earlier to ensure appropriate records were kept and people were not missing medication. Another improvement the service were looking into was using a smart apt on the staff phone which would enable them to scan in and out when arriving and leaving a person's premises. This would enable the service to monitor staff's time management and ensure staff were staying for the correct amount of time in people's homes. It also helped them to afford greater protection to their staff by knowing their general whereabouts.

We found staff records were not standardised so found it difficult to find some information such as staff training records. We raised this with the manager who told us that they were in the process of auditing all the staff files and would ensure records kept in manual files were up to date. The managers were also improving the way they supported staff and had re-introduced an annual staff appraisal system. This demonstrated to us that the management team were monitoring their service and identifying ways to continuously improve the service it provided.