HC-One Beamish Homecare Limited

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Inspection report

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17 August 2018
22 August 2018
24 August 2018

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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?	Good

Summary of findings

Overall summary

The inspection took place on 14, 16, 21 and 24 August 2018. This is the first time we have inspected the service since it was registered in September 2017.

HC One Beamish Homecare Limited 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 older adults. At the time of the inspection there were 19 people receiving a regulated activity.

The service had a registered manager in place. 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.

People and their relatives told us people felt safe receiving support from staff. Staff had completed training in safeguarding and the registered manager raised any safeguarding concerns with the local authority.

Risks to people's safety and wellbeing were assessed and managed. Environmental risk assessments were in place in relation to people's own homes.

People's medicines were administered in accordance with best practice and managed in a safe way.

There were enough staff deployed to meet people's needs. People and their relatives told us staff usually arrived on time. Staff were recruited in a safe way.

New staff told us they received a structured induction programme. They found this supported them in their roles and prepared them to deliver care to people safely. Staff received regular training, supervisions and annual appraisals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice. The principles of The Mental Capacity Act 2005 were applied appropriately in this service.

People were supported to meet their nutritional needs and to access a range of health professionals. Information about healthcare intervention was included in care records.

People and relatives felt the service was caring and staff were friendly. Staff treated people with dignity and respect when supporting them with daily tasks. People were supported to be as independent as possible.

People's needs were assessed prior to them receiving a service. Care plans were in place for meeting each person's individual needs. They were personalised, detailed and included people's preferences. Regular

reviews were carried out with people about their care and support.

People were supported to access the local community and attend outings and events to reduce the risk of social isolation.

People and their relatives told us they knew how to raise any concerns they had about the service. The provider had a complaints procedure in place which detailed how they would deal with complaints. No complaints had been received since the service was registered.

There were audit systems in place to monitor the quality and safety of the service. The views of people and staff were sought by the registered manager via annual questionnaires.

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.

People and their relatives told us they felt safe receiving support from staff.

Staff knew how to safeguard people and any concerns were alerted to the local authority safeguarding team.

Medicines were managed in a safe way.

Is the service effective?

Good

The service was effective.

People and relatives told us staff understood their needs and knew how to support them.

New staff completed an induction programme. All staff received up to date training, regular supervisions and annual appraisals.

People were supported to meet their nutritional needs and to access health professionals when required.

Is the service caring?

Good

The service was caring.

People told us staff were caring.

Staff treated people with dignity and respect and promoted their independence.

People had access to advocacy services.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to them receiving support from the service.

Care plans were personalised, detailed and reviewed regularly with people.

People knew how to raise concerns if they were unhappy with the service.

Is the service well-led?

Good

The service was well-led.

People and their relatives felt the service was well managed.

The provider had an effective auditing process in place to monitor the quality of service provision.

Staff attended regular meetings. The service sought feedback from people via questionnaires.

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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 comprehensive inspection took place between 14 and 24 August 2018 and was announced. We gave the service 24 hours' notice of the inspection visit because it is a community based service and we needed to be sure the office would be staffed. The inspection was carried out by one adult social care inspector.

Inspection site visit activity started on 14 August and ended on 16 August 2018. It included a visit to the office location on 14 and 16 August 2018 to see the registered manager and office staff; and to review care records and policies and procedures. We made telephone calls to staff, people and relatives on 21 and 24 August 2018.

During the inspection we spoke with two people and three relatives. We also spoke with three members of staff, including the area director, the registered manager, a care worker. We looked at three people's care records and three people's medicine records. We reviewed four staff files, including recruitment, training, supervision and appraisal records. We also reviewed other records relating to the management and safety of the service.

Before the inspection took place we reviewed the information we held about the service. This included notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We used the information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection planning we contacted the local authority commissioners of the service, the local authority safeguarding team and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Good

Is the service safe?

Our findings

People and relatives told us they felt safe when receiving support from staff. One person said, "Yes I do (feel safe), to be honest. I've got a good support team here." A relative told us, "I think [family member] feels safer with them (staff) in the shower and things. I have peace of mind with the carers looking after [family member]."

Staff received regular safeguarding training to refresh their knowledge in how to identify potential signs of abuse and how to report any concerns. Staff we spoke with demonstrated knowledge about potential signs of abuse and how to report any concerns.

The registered manager had a safeguarding file that included a log of all safeguarding concerns identified, alerts raised to the safeguarding local authority, investigations and the subsequent action taken. There were no identified lessons to be learnt from records we reviewed. The provider had safeguarding and whistleblowing policies in place. Staff we spoke with told us they were aware of the safeguarding and whistle blowing procedures and would feel confident raising any concerns.

Risks to people's health, safety and wellbeing were assessed and managed. People had risk assessments where required, such as moving and handling and medicines. Risk assessments were stored within care files and were regularly reviewed. All identified risks had appropriate care plans in place which detailed how care was to be provided to mitigate those risks as much as possible.

In addition to risk assessments around people's individual needs there were also risk assessments around the internal and external environment of people's homes.

Medicines were administered and managed in a safe way for those people who required support to take their medicines. Records confirmed medicines were managed safely. We viewed the medicine administration records (MARs) for three people. All records were completed accurately, with staff initials to confirm medicines had been administered at the prescribed dosage and frequency. All staff administering medicines were trained and had their competencies checked to ensure they were safe and experienced to do so. People also had contingency plans for when they refused to take their medicines. These were used to guide staff about what to do and who to report refusals to. For example, contact the office, GP and pharmacy. Regular medicines audits were carried out by the registered manager to identify any errors in administering or recording.

The service recruited staff in a safe way. Applicants completed an application form in which they set out their experience, skills and employment history. All necessary pre-employment checks were carried out for each new member of staff including two references, proof of identification and an enhanced Disclosure and Barring Service (DBS) check. The DBS 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 minimises the risk of unsuitable people from working with children and vulnerable adults.

People told us staff arrived on time and they usually received support from the same care staff. One person said, "It's the same girls that care for me." When asked if staff arrived on time the person replied, "Yes they do." Another person told us, "Yes (staff arrive on time). If there was an accident or something like that its unavoidable but mostly on time." A relative commented, "They turn up on time. They bath [person] and put her to bed on time. Nearly always the same girls, apart from sometimes if they're sick."

The registered manager explained the electronic system 'Business management' which they used to manage people's calls and organise staff rotas. They demonstrated how they arranged rotas and ensured all calls were allocated to staff. All care staff were provided with their individual working rotas every two weeks. The registered manager said, "Staff get two weeks worth of rotas. If there are any changes we send new ones out via email. If it's a short notice change I ring the staff member to inform them." The went on to tell us that people received a copy of rotas weekly to inform them which staff are coming and when.

We viewed a selection of electronic rotas to check that enough staff were deployed to calls. Each individual staff rota contained dates, times of calls, people's names and addresses and what support was required. For example, personal care, medicines, and food preparation. The registered manager told us they considered travel time when organising rotas as well as those calls that were required to be time specific. For example, a person who had to be given paracetamol at four-hour intervals.

No accidents or incidents had occurred since the service was registered in September 2017. The provider had an accident and incident policy in place which detailed what action should be taken if a person or staff member suffered an accident or incident, including what information to record and who to report events to.

The provider had an emergency contingency plan in place for situations such as a lack of staff availability, disruption in IT, severe weather and loss of the telephone network. This plan provided the registered manager with guidance to follow in the event of an emergency.

Staff had received infection control training and were able to explain to us how they promoted this when supporting people in their homes. Care plans included guidance for staff in relation to infection control. For example, details of Personal Protective Equipment (PPE) practices, such as the use of gloves, when supporting people with specific daily tasks and the cleaning of equipment. PPE helps prevent the spread of germs and protects people and care workers from infections.

Good

Is the service effective?

Our findings

People and their relatives told us staff knew people's needs and how to support them. One person said, "They've got to get me showered and dressed." A relative told us staff had "different degrees of knowledge but they still know how to look after [family member]."

Staff told us they received an induction when they first started working for the service and found it useful. The induction programme included mandatory training as well as an introduction to the organisation and corporate policies and procedures. Staff then went on to complete further induction training which incorporated the principles and standards of the Care Certificate as well as some shadow shifts. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. One staff member said, "I did a lot of shadowing, at least 20 hours. It was good, I found it really helpful."

Staff completed a range of both e-learning and face to face training to enable them to carry out their roles effectively. One staff member said, "The training is good. They do it online and face to face. You can do extra training if you want to. I asked for more and was given it." We reviewed training records and found topics included safeguarding, medicines, health and safety, infection control, and food safety. Staff had also completed training specific to people's needs such as Parkinson's Disease, catheter care and Percutaneous Endoscopic Gastrostomy (PEG) feeding. PEG allows nutrition, fluids and/or medications to be put directly into the stomach via a feeding tube. The registered manager said, "Anyone who supports a client with catheter care has received training but in September (2018) every member of staff will complete it also." They went on to tell us they reviewed staff training weekly using the electronic 'Touch' system to ensure training was up to date. They said, "The e learning courses are interactive so they are really good. Better than what was previously in place."

Staff told us they felt supported in their roles and that they received regular supervisions and annual appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. One staff member said, "We have them every one to three months. I find them useful to talk about the job." Records of these meetings showed they were used to discuss their performance and conduct as well as training, team work and personal wellbeing. There were also specific discussions around topics such as new people to the service, medicines management, food preparation in people's homes and safeguarding. All agreed actions were recorded and revisited at the next supervision session.

Staff had annual development plans that were produced from the outcomes of supervisions and appraisals. They included personal objectives, training and actions staff were required to complete to develop in their roles. For example, an action to complete a National Vocational Qualification (NVQ) Level 3 in Health and Social Care with support from the office. The regional manager told us, "HC One are very good with development, the training is excellent. We put carers through an NVQ level 2 and 3 if they want to progress."

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.

We checked whether the service was working within the principles of the MCA. At the time of the inspection everyone receiving support from the service had capacity to make decisions relating to their care. The registered manager said, "If someone lacked capacity to make a decision I would complete a mental capacity assessment and make a best interest decision, unless they had a relative who had power of attorney for health and wellbeing." We saw care plans contained information to support people to make decisions relating to their care. For example, one person's care plan stated, "[Person] can become confused. However, with reassurance and simplifying choices he will be able to make a choice." Staff had received up to date training in MCA and understood the importance of obtaining consent prior to providing support.

At the time of the inspection no one required physical support when eating meals, although staff did prepare food for some people. The registered manager told us, "We would use a MUST Tool if someone was at risk of malnutrition or if staff identified any potential concerns. For example, clothes look too big or food no being eaten and being left to go mouldy. We'd monitor it and if it became a concern we would speak with the person, their next of kin and their social worker, if they had one." Details of people's likes and dislikes in terms of food were recorded in their care files. For example, one person's care plan stated, "[Person] likes cereals, toast, a glass of orange and decaf coffee (for breakfast)."

Records showed people were supported to access external professionals to monitor and promote their health. People's care plans contained records of interventions with pharmacists, GPs, district nurses, occupational therapists and other health professionals involved in their care.

Good

Is the service caring?

Our findings

People and relatives told us they were comfortable with staff and described the service as caring. One person said, "They help me with a shower and everything. The majority like a chat yes. One was a bit quiet at first but she's okay now." Another person told us, "They've all been absolutely great. They've been marvellous from day one." Other comments included, "They're very obliging, they'll do anything for you. They always ask if there's anything else we need", "The carers are helping her more than I ever could" and "We get on extremely well with them all. Lots of chats and laughs with them all. I have nothing but praise for them all."

The service took extra steps to be caring towards people. The registered manager said, "We send birthday cards to all of our clients and if it's a big birthday we also give them a present as well." This meant everyone received a card on their birthday, even those who had no family in their lives.

The registered manager provided people with a 'service user guide' when they first started using the service. The guide contained information about the provider and the service. This included contact details, a guide to what to expect from the service and how to raise any concerns or share their views.

Staff treated people with dignity and respect. One person said, "That's the first thing [care worker] does, she closes the blinds and window (before supporting the person to get dressed/undressed)." Staff we spoke with could explain to us how they respected people's privacy and dignity when supporting them. For example, making sure doors, blinds and curtains are closed before supporting a person to get undressed. Care plans also contained guidance for staff in how to support people whilst maintaining their dignity. For example, one person's care plan for personal care stated, "Once [person] is up and dressed, make the bed and open the curtains."

People's needs had been assessed and appropriate plans of care had been implemented. We reviewed people's care records and observed staff recorded daily notes. Records included details of support provided to each individual as well as people's general mood and if they showed any signs of feeling unwell.

Most people were able to communicate their wishes to staff verbally. However, people who were unable to, used alternative methods of communication. One person's care plan stated their communication had very recently deteriorated and they were no longer able to verbally communicate with staff due to their condition but they could point. The service implemented a wide variety of prompt cards for the person to communicate their wishes to staff. This was also recorded in their care plan with a copy of the prompt cards provided. The registered manager had updated their assessment and informed staff of the changes.

People were supported to be as independent as possible and their capabilities were included in their assessments and support plans. For example, one person's care plan stated, "To assist [person] into the bath seat and control the seat into the water. [Person] can wash himself. However, if required, he may need assistance with hard to reach areas." Staff told us they asked people if they wanted to do anything themselves prior to providing support, to promote independence. One member of staff said, "I let them do

what they can and I'll help them with whatever they need." The registered manager said, "As home care we promote independence so staff try to encourage people to do things for themselves that they are able to do. They will support people if they struggle."

Most people receiving support from the service could express their own views and opinions about their care and about the service in general. Where necessary, relatives acted on behalf of people. The registered manager told us at the time of the inspection that no one had an advocate acting on their behalf. Advocates help to ensure that people's views and preferences are heard. The registered manager was able to explain how advocacy services would be arranged should they be needed. They said, "I would contact the local authority initially but also know there are local advocacy services." They went on to tell us they would support the person to obtain suitable advocacy support if needed.

All files containing confidential information including people's care files, staff files, daily logs and other records relating to the service were securely stored. Computers were secure and only accessible to dedicated staff. The registered manager said, "Either myself or the senior carer take copies of care plans and assessments to people's houses. We don't like to send them through the post as they contain a lot of confidential information." This meant people's private information was stored securely and confidentiality was maintained.

Good

Is the service responsive?

Our findings

People had their needs assessed prior to receiving care and support. Assessments were used to gather personal information about people to help the registered manager understand their needs and to inform care plans. Information gathered included health, cognitive and physical needs. They also included details of family and life history. The registered manager told us, "When we get new people I go out to do the assessment. I try to get as much information as possible so I can try to match the most suitable staff to them. It's important that they feel comfortable with the staff and have compatibility." They gave us an example of one person who loved classical music and used to play the violin. They matched them to a member of staff who played the cello and shared their interest in music.

People had care plans in place to meet the needs identified in their assessments. Care plans were detailed and contained people's choices and preferences. Care records were personalised and reflective of people's individual needs. They also included daily routines for people which detailed how staff were to support people from the point of arriving at a person's home and how to enter their property to providing all support and leaving. For example, one person's care plan stated, "[Person] will answer the door. However, if he does not, home support can open the door and shout 'hello'. If the door is locked there's a key safe in place."

People had a range of care plans in place to meet their needs identified in their pre-assessments. Areas covered included personal care, medicines, nutrition and hydration and moving and handling. Care plans were detailed, personalised and included people's choices, preferences, likes and dislikes. For example, one person's care plan stated, "[Person] likes to use radox shower gel and dries her body with soft pink towels." Another person's care plan stated, "[Person] prefers a full body wash."

The registered manager told us, "Every six months we go and do a review with the client (regarding their care). We ask is there anything you want to change? and Are staff arriving on time?" They used a matrix to monitor when care plan reviews were completed and when they were next due to take place. They also explained that additional reviews were also completed if and when people's needs changed. Care plans we viewed contained person-centred reviews which looked at all aspects of the care they received. For example, assessments, what's working well, what could be better and any suggestions for improvement. Care plan reviews had been completed with people during home visits. Any actions identified during reviews were recorded and signed off when completed.

Staff monitored the health and wellbeing of people and completed a log if people were showing signs of feeling unwell, if they had hurt themselves or had any marks such as a red rash. Logs included any action the staff member took such as calling the GP or nurse.

People were supported to access the local community as well as prepare for transitions to residential services. The registered manager told us and newsletters showed people receiving home care where encouraged to take part in community outings to places such as museums and local attractions. They were also invited to attend events at one of the provider's large residential services. For example, entertainment evenings with singers, parties and summer fayres. The registered manager told us this was to try and reduce

social isolation and improve people's quality of life. They also explained the benefits of people experiencing life in a residential setting for future transition plans.

People and their relatives told us they had no complaints about the service but would feel comfortable raising any concerns. One person said, "Complaints? Nothing at all, honestly." Another person told us, "No I don't think so. Nothing to complain about." A relative commented, "No complaints, I wouldn't complain about anyone in the whole of HC One." Another relative said, "We don't have any issues. No complaints."

The provider had an up to date complaints policy and procedure in place which was included in the 'service user guide' given to people when they started using the service. The service had not received any complaints since they registered in September 2017.

At the time of the inspection no one was receiving end of life or palliative care. The registered manager told us about a person who was receiving end of life care but had recently passed away. One person had a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) which was incorporated into their care records. Records showed discussions had taken place with people regarding their wishes in relation to end of life care. Records we viewed indicated they did not wish to discuss the topic at this time. The provider had an end of life policy and procedure in place that set out the values, principles, and practices they would adopt in their approach when supporting people with a terminal illness.

Good

Is the service well-led?

Our findings

People and their relatives told us they felt the service was well managed. One person said, "Actually my care is excellent all the way through." A relative told us, "The service [family member] is getting from all the girls is nothing short of super." Another relative commented, "It (the service) runs fairly smoothly."

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. The registered manager clearly understood their responsibilities as a registered manager and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

We received positive feedback from people regarding the management of the service. One person said, "[Registered Manager], I've met her yes. She's come out to see me. She's been very, very helpful." Another person told us, "Some of the office staff have come out (to see me), including [registered manager]." The registered manager said, "If I'm out doing an assessment or something, I'll pop and see a client as well to see how they are. Plus, I think it's important they see me. I've met everyone (who receives a service) and have a good relationship with clients."

During the inspection we asked for a wide variety of records and documents from the registered manager. We found records were easily accessible, stored securely and well maintained. Throughout our inspection we found the registered manager and staff to be open, approachable and cooperative when we spoke with them.

The service had out-of-hours arrangements in place to ensure staff members were able to contact a member of the management team if necessary. The registered manager said, "There is an on-call mobile phone that goes between the administrator, the senior and myself. There's always an area director on call (also) and we would know who that was so if there was something I couldn't deal with we would contact them."

Meetings took place between office and care staff every two months to discuss all aspects of the service. Minutes of meetings showed discussions included new staff members and recruitment, staff training, uniforms, policies and procedures, care plans, medicines management and staff competencies. Minutes of meetings were sent out to every staff member to ensure they had access to a record of what was discussed.

People and staff were asked for their views via an annual questionnaire. Questionnaires were due to be sent out for 2018. These were the first questionnaires to be sent out since the registration of the service in September 2017. The registered manager said, "They're all ready to be posted because they get sent out in September every year." We saw these were prepared and ready to be posted. From care plan reviews we noted that everyone was happy with the support they received and comments regarding the service included "excellent" and "good service."

The registered manager completed a number of audits around the quality and safety of the service. These

included care plan audits, checks of daily records, and medicines audits. All findings were recorded as well as any required actions. The registered manager told us, "We monitor call logs as well. We'll randomly ring one of the clients and see how they are and how things are, if they're happy."

The area director visited the service monthly to touch base with the registered manager. They completed regional audits on a bi-monthly basis which covered client care, complaints, incidents, safeguarding trends, management alerts, care planning feedback, staffing, training and staff engagement. All actions identified were recorded and reviewed during the next office visit. The audits were used to drive improvement in the service.

The service had received three compliments in the form of 'thank you' cards since the service was registered in September 2017 from relatives of people who had previously received support. Comments included, "Thank you, your service was excellent and I will definitely recommend you," "Thank you so much. Service was excellent," and "Thank you for being so caring."

The registered manager sent out monthly newsletters to every person who received a service. information included a welcome note for new people to the service, short breaks, experience days and outings, invitations to write a review of the service, kindness in care award and contact details and address for the service.

The provider operated a 'Kindness in Care Award. The registered manager said, "Staff can be nominated by another member of staff or a client or relative. Everyone is given a nomination form (to use as and when they want to). We email all nominations received to head office and a winner is chosen." They went on to tell us the winner received a £50 gift certificate and a badge. This meant there were incentives in place to encourage staff performance.

The service recently won a Top 20 Award from a national website. The registered manager told us, "They do team awards as well. I nominated the whole team for a team award because they won the Top 20 Award 2018. They were awarded a group gift certificate." The registered manager used the gift certificate to buy each member of staff an individual gift.