Momentum Care And Support (Yorkshire) Limited

HCF The Springs

Inspection report

HCF The Springs, Southmoor Road
Hemsworth
Pontefract
West Yorkshire
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Tel: 01977612789

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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

This inspection took place on 31October 2016 and was announced. The previous inspection took place on 18 February 2014 and we found that the registered provider met the requirements that were in place at that time.

HCF The Springs is a domiciliary care agency that is registered to provide the regulated activity personal care. This includes support with activities such as washing and dressing, the provision of meals and the administration of medication for people living in their own home. On the day of the inspection one person was receiving support from the agency every day over a 24 hour period, and another person was receiving support on an occasional basis. The agency office is in Hemsworth, close to the town of Pontefract, in West Yorkshire. There is easy access into the premises and parking is available for people who wish to visit the agency office.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. Some notifications had not been submitted to CQC by the registered provider. This meant that we were not able to determine whether appropriate action had been taken following any accidents or incidents. We have made a recommendation about this shortfall.

We found that staff were suitable for the role for which they had been employed although more care needed to be taken to adhere to the agency's recruitment policies and procedures. We saw there were sufficient numbers of staff employed to meet people's individual needs.

We found that people were protected from the risk of harm or abuse because the registered provider had effective systems in place to manage any safeguarding issues. Staff received training on safeguarding adults from abuse at the time of their induction and then as refresher training, and understood their responsibilities in respect of protecting people from the risk of harm.

Staff confirmed they received induction training when they were new in post and told us that they were happy with the training provided for them. The training records showed that all staff had completed induction training and the training that was considered to be essential by the agency.

People received the right medication at the right time, and records of the administration of medication were satisfactory.

People's nutritional needs were assessed and special diets were catered for. People were supported to access appropriate health care services to monitor and improve their well-being. Any accidents and incidents were recorded thoroughly.

It was apparent that care workers genuinely cared about the people they supported. The feedback we received confirmed that the person who received regular support had positive relationships with care workers and the registered manager. It was clear that care workers and the registered manager knew this person's physical and emotional care and support needs very well.

There was a complaints policy and procedure and this had been made available to the person who received a service and their relatives. At the time of this inspection, no complaints had been received by the agency. There were systems in place to seek feedback from people who received a service and we saw that this feedback was positive.

We received positive feedback about the management of the service from everyone who we spoke with.

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 were sufficient numbers of care workers employed to ensure people received the service that had been agreed with them, and the staff employed were suitable for their role.

Staff received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse to the relevant people.

Any identified risks were recorded and managed with the aim of minimising or eliminating the risk.

Is the service effective?

Good

The service was effective.

The registered manager and staff understood their responsibilities in respect of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff had received training that equipped them to carry out their role, both as induction training and refresher training.

People were supported and encouraged to have contact with health care professionals.

Is the service caring?

Good

The service was caring.

The feedback we received showed that care workers genuinely cared about the people they were supporting.

People's individual care and support needs were understood by care workers, and people were encouraged and supported to be as independent as possible.

Privacy and dignity was respected by staff.

Is the service responsive?

Good

The service was responsive to people's needs.

Care plans recorded information about each person's individual care needs, and their care needs were regularly reviewed.

People were invited to give feedback on the care and support they received.

There was a complaints procedure in place and although no complaints had been received by the agency, there were systems in place to record the action taken if any complaints were received.

Is the service well-led?

Good

The service was well-led.

There was a manager in post who was registered with the CQC. Care workers and a relative told us that the service was well managed.

The registered provider had not informed the CQC of accidents and incidents that had occurred as required by regulation.

There were systems in place to monitor the quality of the service and identify any required improvements.

HCF The Springs

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.

The inspection took place on 31 October 2016 and was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be at the agency office who could assist us with the inspection. The inspection was carried out by one adult social care inspector.

Before this inspection we reviewed the information we held about the agency, such as information we had received from the local authority who commissioned a service from the registered provider and feedback from people who used the service.

The registered provider was asked to submit a provider information return (PIR) before this inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was returned within the required timescale.

On the day of the inspection we spoke with one person who used the service, a care worker and the registered manager. We also spent time looking at records, which included the care records for two people who used the service, the recruitment records for one care worker and other records relating to the management of the service, including quality assurance, staff training, health and safety and medication. The day after the inspection we spoke with a relative and a care worker to ask for their views about the service provided.

Good

Is the service safe?

Our findings

A relative who we spoke with told us that their family member was very safe whilst being supported by staff from HCF The Springs. She said, "Oh yes, [name] has 24 hour care."

We checked the recruitment records for one care worker and saw that employment references had been obtained; one of these was a verbal reference and there was a full report of the conversation that had been held with the referee. We advised that written references should be sought apart from in exceptional circumstances. The Disclosure and Barring Service (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 helps to prevent unsuitable people from working with children and vulnerable adults. We saw that the care worker had a DBS check in place although it had arrived after they had commenced work for the agency. The care worker had supplied an 'old' DBS check from their previous place of employment as additional evidence.

We recommend that the registered provider ensures all recruitment checks are in place prior to staff commencing work with people who receive a service. This would ensure that only people considered suitable to work with vulnerable people were employed at HCF The Springs.

We saw that there were sufficient numbers of staff employed to ensure people received the service that had been agreed with them. The agency employed three care workers, a 'bank' care worker and a driver / administrator. Care workers worked from either 9.30 am until 5.30 pm or from 5.30 pm until 9.30 am. The registered manager covered any shifts that could not be covered by care workers. This ensured the person who received a service from the agency was supported over a 24 hour period. Another person received care and support from the agency on an occasional basis and staff worked additional hours to make sure this person received the support they required.

We checked the care plans for the two people who received a service from the agency and saw they contained a risk assessment that recorded any identified risks in respect of the person's care, such as self-medication and the risk of falls. We noted that risk assessments were positive and were designed to enable the person to take responsible risks and remain safe. There was also a risk assessment in respect of the person's accommodation that identified potential risks and the action that had been taken to avoid harm, such as fixing wardrobes to the wall. Support workers slept overnight at one person's home; the registered manager told us that the person remained safe as there was in infra-red light that alerted staff should the person move downstairs. This was because they were not safe to enter the kitchen unaccompanied.

The registered manager told us care workers completed training on safeguarding adults from abuse during their induction period and as refresher training, and the staff who we spoke with confirmed this. The care workers who we spoke with were able to describe types of abuse they might become aware of and were clear about the action they would take if they had any concerns. They told us that they would report any concerns to the registered manager, and were certain the information would be shared with the relevant professionals, in accordance with the agency's policies and procedures.

There was a system in place to record any accidents and incidents and these were also recorded within people's care plans. There had been two incidents between a person who used the service and staff, and we saw that management plans had been put in place to help prevent them reoccurring. One person had fallen and we saw that a referral had been made to the occupational therapist (OT) as it was felt that the fall had occurred due to the person's gait.

Any anticipated behaviours that could challenge the service were recorded in care plans as 'reputations'. These described certain behaviours that might occur, what they might indicate about the person and how staff should act to diffuse the situation. For example, one person's care plan recorded what staff could do to avoid a change in their behaviour when they were out shopping as 'Ask me what I am hoping to buy when I go shopping'. Another entry recorded, 'When I repeat questions this means I am getting bored' and 'Support me by promoting activities'. This meant that staff had been provided with advice on how to diffuse situations that might occur.

There was a business continuity plan in place that recorded the action that would be taken to ensure the service could continue to operate in emergency situations, such as theft, IT system failures, loss of power, fire and staff shortages. The document included a list of contact numbers for staff and other people who may need to be contacted in an emergency. The registered provider was able to access this and other information from their own home if they were not able to gain entry to the agency office. The registered manager told us that there was also a list of all staff names and telephone numbers in the home of the person who regularly used the service, plus other emergency numbers.

We saw that medicines were managed safely. One person who received support from the agency required their medication to be administered by support workers. There was a risk assessment in place that recorded the person was not able to self-medicate. Their care plan recorded, 'Medication must be given on time and signed for'. The registered manager told us that medication was stored in a locked metal cupboard in the person's home and that the medication held and medication records were checked during each spot audit.

The registered manager told us that a monthly supply of medication was provided in blister packs. They said that support workers used a weekly medication administration record (MAR) chart as they found this easier to complete than a monthly MAR chart. We saw a sample of MAR charts and noted that they included details of any allergies the person had, the name of their GP, a photograph of the person and appropriate codes to record the reason when medication was not administered. If any new medication was prescribed mid cycle, the pharmacist provided a label to be added to the MAR chart. This reduced the risk of errors occurring. The relative who we spoke with told us there had never been any concerns in respect of medication for their relative.

Good

Is the service effective?

Our findings

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 MCA 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. For people living in their own home, this would be authorised via an application to the Court of Protection. We checked whether the service was working within the principles of the MCA and found that the registered manager understood these principles and was following them. No applications had been made to the Court of Protection.

One person's care plan included a mental capacity assessment that assessed their capacity to make decisions in respect of how they handled money, how and when to take their medication, the need for blood tests and attendance at the foot clinic.

Care workers described to us how they would assist people to make day to day decisions, such as showing them options and giving them enough time to make a choice.

We saw the induction training records for one member of staff. Training had taken place over six days and the topics covered included whistle blowing, complaints, first aid, the control of substances hazardous to health (COSHH), core values of care and moving and handling. In addition to this, the new employee had attended training on managing violence and aggression / breakaway techniques.

The registered manager told us that the training considered to be essential by the organisation was their fundamental skills training. This included equality and inclusion, duty of care, fire safety, health and safety, safeguarding adults from abuse, communicating effectively, MCA, personal development and the role of the health and social care worker. There was an expectation that staff attended refresher training each year, and the records we saw confirmed that this was taking place. In addition to this, two of the support workers had achieved a National Vocational Qualification (NVQ) in Health and Social Care at level 2 or 3.

Staff told us they had formal supervision meetings with the registered manager and that they completed a self-assessment as part of this process. They told us they felt well supported. One support worker said, "There are only three of us so we are a tight-knit team. We see each other every day."

One person who received a service required support with the provision of all meals and drinks. The staff 'daily routine' document recorded that the person was on a low cholesterol diet. We saw one of the food logs and noted that the person's meals for breakfast, lunch, tea and supper were recorded each day. There was also a weekly menu, although the registered manager told us that staff often deviated from that to meet the person's meal requests. The person who received a service had been assessed by a Speech and

Language Therapist (SALT) and they had recommended that they had a soft diet due to having no teeth. The report from SALT and a written summary of the visit was included with the person's care records.

A relative told us that meal provision for their family member had improved since they started to receive one to one support. They told us, "They previously had ready meals but staff now make [name] freshly cooked meals."

There was a record of all contact the person had with health and social care professionals. One person's records showed they had recently had contact with a dietician, an urologist, a dentist and a chiropodist and events such as flu vaccinations were also recorded. The registered manager told us that 12 monthly reviews were also carried out by the learning disability team. These records showed that staff were promoting good general health and well-being for the person concerned.

A support worker told us that one person who used the service had started to gain weight. They said, "The registered manager and I go to the GP's surgery with [name]. They are seeing a dietician there and their weight is steadily coming down."

There was an in-depth health action plan in place and this included the details of these health professional visits. The registered manager told us that the person would take the health action plan to any hospital appointments or admissions with them so that it could be viewed by hospital staff.

Good

Is the service caring?

Our findings

The relative who we spoke with told us that staff seemed to genuinely care about their family member. They said, "There are only a few staff now and they are genuinely fond of [name]. They put his needs first" and "The girls are very patient with [name]." They also mentioned the driver / administrator and said, "They have a lovely relationship with [name]." A support worker said, "We genuinely care about people. We would tell straight away if a new worker was not right for the job."

The registered manager told us that there was a photograph board in the home of the person who regularly used the service so there was a pictorial record of the next member of staff on shift. This meant the person who received a service always knew who would be supporting them.

A relative who we spoke with told us that their family member had improved since they had started to receive one to one support from staff at the agency. This was partly because their family member always knew who would be supporting them. Staff 'handed over' to the next care worker on shift so there was never an occasion when the person had been left without appropriate support.

A relative told us that they were kept informed of any information that might affect their family member. They said, "They contact me if [name] has another infection coming on or with any other concerns." They said that it was easy to contact the agency office and that they had a mobile telephone number for the registered manager.

We asked the registered manager about advocacy services. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. They told us that an Independent Mental Capacity Advocate (IMCA) had worked with the person who used the service to discuss their frequency of urine infections and the procedures that might be required to investigate these further. IMCA's offer an advocacy service for people who lack capacity to make decisions for themselves. This showed that the registered manager encouraged and supported people to use available advocacy services.

We asked staff how they ensured they protected people's privacy and dignity whilst assisting them with personal care. They told us they helped one person to run a bath, left them alone for a while and said, "Shout if you need me." They said they placed a towel around them as soon as they stood up.

Discussion with the registered manager and staff revealed there were people using the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for by the service. The care records we saw evidenced this and the registered manager and care workers displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. It was clear when we met a person who used the service with a support worker that there was a positive relationship between them.

Support workers told us they supported people to be as independent as possible. A care worker told us that they encouraged one person to dress and undress and to wash themselves, as they were capable of doing this. They said they encouraged people to try to do as much as they could for themselves but then assisted them if it was clear they needed support.

Good

Is the service responsive?

Our findings

We reviewed the care records for the two people who received a service from the agency. The initial assessment included information about waking / dressing, retiring / undressing, food and drink, medication, personal hygiene, health and medical care, daily lifestyle activities, social needs, communication and religion. Other assessment information included the contact details for their family, their life history so far, their likes, dislikes and preferences, their daily routines and how they communicated. There was a person-centred plan that had been produced in pictorial format to help one person who received a service to understand it. This care plan was written in the first person and included questions such as, 'Who will help me with my money and shopping?' and the explanation, 'The person's relative is their appointee. Support staff will help with daily money, keeping accurate records (financial) and receipt for every transaction. Cashbox checked at every staff handover.'

One person's care plan included information under the headings 'What should happen in your life' and 'The support you need to make this happen' and covered areas such as their regular activities and their dreams and wishes. Additional information recorded that the person liked to go on holiday and to visit a specific museum, and the action plan recorded who would arrange these holidays and visits, who would accompany the person and when this would be carried out.

We saw that support staff used a communication diary for one person where they recorded food and fluid intake, activities taken part in and the person's mood. If they were concerned about the person's mood or behaviour, they completed hourly monitoring sheets so that they were able to see if any patterns were emerging and to help them decide if any additional support was needed.

The registered manager told us that they reviewed each person's care plan every three months and then again every 12 months. We saw that there had been regular updates to the information held in care records.

We asked care workers how they got to know about people's individual needs and they told us they would look at the person's care plan before they started to support them. We saw that care workers had signed a document to evidence they had read each person's care plan, and it was clear that care workers had a good understanding of people's individual care and support needs.

One person had a weekly activity planner in place that recorded activities for each morning, afternoon and evening. When we met this person they told us about a Halloween party they would be attending that week, the outfit they would be wearing and the staff member who would be going with them. They said they were looking forward to the party as some of their friends would be there. There was also a staff 'daily routine' document in place that recorded information such as what the person liked to have for their breakfast, their bathing routine and the times they needed to take their medication.

We saw copies of satisfaction questionnaires in people's care plans. One person received a 'standard' questionnaire and one person received an 'easy-read' version of the questionnaire that the person could relate to. The relative we spoke with told us that they also received a satisfaction survey. All of the responses

we saw were positive.

We saw that a copy of the agency's service user guide was given to people who used the service. This also included pictures so that it was more accessible to people. The service user guide included information about the complaints and compliments procedure.

No complaints had been received by the agency. The registered manager monitored and recorded compliments and complaints each month. No complaints had been received by the agency. We checked these records and saw that two compliments had been received during 2016, one from a relative and one from Calderdale CCG. They had commented on a person's improved behaviour.

Staff told us they were confident people would tell them if they had any concerns. They said they would make a complaint on one person's behalf as they would have difficulty understanding the process. They added that they were certain anyone's complaints or concerns would be listened to and acted on.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had not submitted any notifications during the previous 12 months and we saw two safeguarding incidents that had occurred between a person who used the service and a staff member that required a notification to be submitted to CQC.

We recommend that the registered provider checks the information on the CQC website about submitting notifications, and follows that guidance.

The registered manager was a registered nurse and had completed re-validation in order to retain their registration. They told us that they read articles in journals and checked the CQC website to keep their practice and knowledge up to date. They had attended recent training on managing violence and aggression and study days on MCA / DoLS and percutaneous endoscopic gastrostomy (PEG) feeding and were able to share their learning with support workers. PEG feeding is when a person is fed via a tube directly into their stomach.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

The registered manager carried out 'spot audits' at one person's home; the other person only received an occasional service. They checked daily reports, the cash box, medication, hazards and the practice of the support worker. The registered manager also took part in some staff handover meetings so that they were always aware of the current situation with the person who received support.

We saw the records of staff meetings that had taken place in May, August and October 2016. The topics discussed included MCA / DoLS training, staff handovers, consultation about shifts and monies of people who used the service. Staff were reminded to always sign MAR charts. These arrangements gave staff sufficient opportunity to discuss any concerns and to give feedback about the service provided.

We asked the registered manager about the culture of the service. They described it as, "Promoting independence and supporting people to be part of the community." They told us that they were a small staff team who were flexible and able to offer high quality care. Some of the team had specialist qualifications, including nursing. This meant they were often able to spot when health concerns were developing and ensure the person received prompt attention from health care professionals. A support worker described the agency as, "Small and intimate, more individualised" and said that people received a consistent service.

The relative who we spoke with told us the service was well managed. Care workers told us that the registered manager was, "Always clear about their expectations of us" and that there were no problems with how the agency was managed. They said there was a form they could complete to record any concerns and worries, and this type of information was used to make improvements to the service.