Snowball Care UK Ltd

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 7 and 9 February 2017 and was announced. This was the first inspection of regulated activity carried on by the provider since it registered to deliver personal care in 2016. The provider had previously registered with CQC as Snowball Care and was rated as good at its inspection on 16 July 2014.

Snowball Care UK Limited is a domiciliary care provider people. At the time of the inspection the service was providing support to 84 people. People receiving support included older people and people with a learning disability.

The service had a registered manager at the time of the inspection. 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.

Staff were trained to keep people safe and report any suspicion of abuse. The likelihood of people experiencing avoidable harm was reduced because the manager assessed people's risks and developed plans to mitigate them. There were sufficient numbers of vetted and safely recruited staff to deliver care and support as planned. Staff provided people with the support they required to take their medicines safely.

People received care and support from trained, skilled and knowledgeable staff. People received the support they required to eat and drink. Staff supported people to maintain their health and access healthcare professionals as their needs required.

People received care from staff who were caring. Staff supported people to make decisions and maintain their independence. People's privacy was respected and their dignity was promoted. People received support from consistent staff enabling positive relationships to develop.

People had their needs assessed and reassessments were also carried out when people's needs changed. People's care was delivered at times they choose and the service provided bi-lingual staff to meet people's cultural and communication needs. People shared their views with the provider about the care they received and complaints were dealt with appropriately.

The service had a registered manager who was a qualified social care professional. There was an open management style at the service. The provider undertook checks and audits to monitor service delivery and drive up improvements.

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

People were safe. Staff were trained in safeguarding procedures and knew how to identify signs of abuse.

People's risks were assessed and plans were in place to mitigate them.

People were supported by staff who had been recruited through a robust process.

Staff were trained in medicines administration and supported people to receive their medicines safely and as prescribed.

Is the service effective?

Good

The service was effective. Staff received training to meet people's needs effectively.

The manager and care coordinators supervised staff.

People were supported to meet their nutritional needs.

Staff made timely referrals to healthcare professionals.

Is the service caring?

Good

The service was caring. People told us that staff were caring and kind.

People received continuity in their care from familiar staff.

People's independence was promoted.

Staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and their care was planned and timed to meet their needs.

People's cultural and language needs were met by the provider's staff matching processes.

People's complaints were addressed appropriately and in a timely manner.

The provider actively sought the views of people about their experience of the care provided.

Is the service well-led?

Good

The service was well-led. There was a registered manager in post who was open and approachable.

Staff felt supported by the registered manager and the leadership team.

There were robust quality assurance processes in place to monitor and improve the service.

Snowball Care UK Ltd

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 announced inspection took place on 7 and 9 February 2017. The provider was given 48 hours' advance notice because the location provides a domiciliary care service and we needed to ensure the registered manager and staff were available. It was undertaken by one inspector.

Prior to the inspection we reviewed the information we held about Snowball Care UK Limited including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We used this information in the planning of the inspection.

During the inspection we spoke with nine people, the registered manager and the director. We also spoke with three staff. We reviewed 16 people's care records, risk assessments and medicines administration records. We also looked at documents relating to staff and management. We reviewed 10 staff files which included pre-employment checks, training records and supervision notes. We read the provider's quality assurance checks and records relating to the management and running of the service. We looked at complaints and compliments from people and their relatives.

Following the inspection we contacted five health and social care professionals to gather their views about the service people were receiving.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "The [staff] do their jobs properly so I am safe and fine." Another person told us, "The staff are nice and friendly. I trust them. I don't worry."

People's safety was improved by the support they received from staff who were trained to identify and respond to suspected abuse. Staff received safeguarding training and understood the provider's safeguarding procedures. A member of staff told us, "It's important to be observant, listen to people and to build a trusting relationship so people can say if they're scared or something has happened. I would report any concerns they had or I had to my manager." Another member of staff said, "If I thought someone was at risk of abuse I would immediately tell my manager who would tell the relevant social worker."

People's risks of avoidable harm were identified and reduced. People received risk assessments as part of their needs assessments prior to receiving a service. Where assessments identified risks plans were developed to manage them. Risk management plans were included within care records to guide staff. For example, staff supporting people who may be at risk of falling were instructed to identify tripping risks such as wires along floors and lifting rugs. When staff observed a decrease in people's mobility or increasing unsteadiness when on their feet, referrals were made to occupational therapists for assessments to be undertaken. This meant people's risks of falling were identified and mitigated.

The registered manager reviewed accidents and incidents reports. This monitoring led to action to keep people safe. For example, the registered manager updated care records and guidance to staff following an incident to prevent a reccurrence. Where issues of concern were raised about people's environments care staff informed office staff who took action. For example, when one person's heating had broken down the service contacted contractors who undertook repairs.

The provider deployed enough staff to meet people's needs. People and staff received rotas in advance showing how staff would be available to deliver care as planned. To manage the risk of late and missed care visits people had designated care staff who lived within walking distance of them. The manager organised the rota to ensure that each care visit had a named alternative member of staff to be called upon should the designated care staff be unavailable.

Care records provided staff with details of people's preferences for how staff should gain entry into their homes. For example, one person's care records informed staff that the person would use an intercom system to let staff in to provide care. Whilst another person's care records advised that staff should use the key safe. Where people were able to open their doors to let in staff this was stated in care records. Staff also had guidance on the actions to take if people did not respond as planned to their arrival at people's homes. This included contacting the office from where coordinators would phone family members. Emergency services were summoned in line with risk assessments. This meant the provider took steps to ensure people's safety if care could not delivered.

People received support from staff who were recruited safely by the registered manager. Prospective staff

submitted applications and selected applicants were interviewed. Those who were successful submitted references, proof of identify and underwent vetting against databases containing criminal records and the details of individuals who are not permitted to work with vulnerable adults. This meant staff were suitable to deliver care.

People received their medicines in line with their assessed needs. People told us that staff provided them with the appropriate level of prompting to ensure their medicines were taken as prescribed. Staff maintained medicines administration records [MAR] sheets. The registered manager and director regularly reviewed MAR sheets to ensure they were accurate.

The risk of people acquiring infection whilst receiving personal care were reduced because staff used personal protective equipment (PPE). The PPE worn by staff included, gloves, aprons and shoe covers. By disposing of PPE after each use staff prevented people's exposure to cross contamination.

Good

Is the service effective?

Our findings

People told us that staff delivering their care had the skills and knowledge to do so. One person told us, "They know how to do all that is asked of them." Another person said, "They do the job properly, probably because it's in their nature. They're naturally caring and they get trained up."

People were supported by staff who received an induction. New staff received induction training which included three days of classroom based training. The training covered during these sessions included moving and handling, safeguarding and learning about the provider's procedures. Induction also included two days of shadowing experience to observe good practice and deliver support under close peer supervision.

Staff received training to meet people's needs. The provider arranged for training sessions to be delivered each week. This enabled staff to regularly undertake mandatory training in subjects such as infection control and medicines. Staff also received training in areas specific to the needs of people they supported. For example, staff attended training sessions focused on dementia and behavioural support needs. Following each training session staff completed knowledge papers to test what that had learned. A member of staff told us, "We get booklets from the trainer which helps later on. They are like refresher material and they remind you about the key things you learnt."

Most staff had received supervision and the registered manager had completed a plan to ensure all staff were supervised and appraised using a new recording format. During supervision staff and managers discussed issues which included peoples' changing needs, relationships with people's relatives, rotas and training. This meant people had their care and support delivered by staff who were supported in their roles.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff we spoke with understood people's rights under legislation. One member of staff told us, "We always assume people have the capacity to choose and make decisions unless it's obvious they don't. Another member of staff said, "When we think people have lost capacity we tell the manager and she would sort out a best interests meeting." Records showed people, their relatives and social workers discussed people's best

interests in meetings about their mental capacity, risks and support needs.

People received the support they required to meet their assessed nutritional requirements. One person told us, "I don't need any help to eat at all but I can't make dinner like I used to. The [care staff] do that for me every day." Staff prepared people's meals in line with their care plans and preferences. Records showed, and people confirmed that drinks were prepared for people during care visits and left within reach as staff finished their care visits.

People were supported to maintain their health. One member of staff told us, "To avoid a urinary tract infection I leave water and support [person's name] to go to the toilet before I leave." Staff supported people to make and attend appointments with healthcare professionals and recorded outcomes as required.

Good

Is the service caring?

Our findings

People were supported by caring staff. One person told us, "My [staff's name] is wonderful. She comes to me throughout the day and makes sure I am alright. She's like one of the family, honestly." Another person said, "The care [staff] are lovely. They're very kind."

Staff knew people well. The provider operated a keyworker system to coordinate staff. Each person had one named care staff responsible for delivering their care and support. A member of staff told us, "I see the same person four times a day so I know them and their family really well." In addition to the named staff member people also had an allocated 'back up' member of staff who delivered support when the main care staff was unavailable. This meant people had continuity in the care staff supporting them

People told us that staff supported them at a pace they were comfortable with. One person told us, "It would be nice if they could stay longer but I don't feel like they are rushing me." A member of staff told us, "We talk for a while before [person] gets up because [they] need to be mentally alert before becoming physically active". Another member of staff said, "You can see how frustrating it is for some people being so stiff in the morning. They don't want to be slow but if they rush it can cause pain. So I always speak calmly and tell them not to rush and everything is fine."

People made decisions about the care and support they received. Care records showed people's involvement in their needs assessments and care plans which stated their preferences for how their needs should be met. People also made day to day decisions about their support. A member of staff told us, "I can say no one I support wants to wash the same way. Some bath, some strip wash, some use soap, some use shower gel, some use a flannel, some use a sponge and some change their minds. It's fine, I just let people choose."

People had access to information about the service they received. At the point of their service starting the provider issued a booklet to people entitled 'Welcome to our service'. The document contained sections which included "Complaints and your rights" and "Rights to make choices and be treated with dignity." We found that all emails concerning people between the registered manager and health and social care professionals were retained in a correspondence file within peoples' electronic care records. People had access to this information upon request.

People were supported, to maintain their independence. One member of staff told us, "I support people to do as much for themselves as they can. For example, one person can comb their hair independently but I have to hand them their brush and always make sure I compliment them afterwards." Another member of staff told us, "There's pride in doing for self, even if it takes a while. I support one person who wants to cook but understands they need to be supervised or it would be dangerous for them." Care records gave staff guidance as to people's individual levels of independence with specific tasks.

Staff maintained people's dignity and treated them with respect. One person told us, "I really wish I could take care of everything myself but I can't. I can say though that staff have never made me feel awkward or

uncomfortable about personal care." A member of staff told us, "During personal care we talk about anything other than personal care. No-one wants to talk about using the commode when they are using it." Another member of staff told us, "I always explain why I wear gloves during personal care as some people find it off-putting. I explain that it is to protect them from infection and cross-contamination because I support a number of people each day with their personal care."

Good

Is the service responsive?

Our findings

People's care met their individual needs and preferences. People received their care visits at times and for durations they negotiated with funding authorities and the provider to meet their needs. The frequency with which people received care visits ranged from one care visit per week to four care visits each day. Similarly, the durations for care visits varied. Records showed that some people's needs could be met in 30 minutes whilst other people required one hour of support. The provider regularly reviewed the care and support people were receiving to ensure that people's needs were being met.

When people's needs changed they were supported to have reassessments. Records showed that the provider made referrals to health and social care professionals to review people's changing needs. Similarly, when staff identified new needs for people starting to receive a service the registered manager made referrals. For example, when people presented with pressure ulcers referrals were made to the community nurse for treatment and an occupational therapist for guidance on the correct moving, handling and transferring equipment. This meant people's needs were identified and met.

People received the support they required to participate in the activities they chose. People were supported with activities in line with their funded care packages and personal preferences. For example, one person with a learning disability was supported to visit museums, the gym and swimming baths. Whilst an older person was supported to go the shops. Some people told us they liked to watch television during the day but required staff to turn their TVs on. They said staff turned their televisions to their preferred channels and left the remote controls within easy reach.

People for whom English was a second language had their needs met by matching them with bi-lingual staff. The provider recruited staff to reflect the cultural diversity of the people receiving a service. We found that people who spoke Greek, Bengali, Arabic, Spanish and Portuguese were receiving support from staff who spoke those languages too. People's preferences for same gender carer staff were also met.

People knew how to complain. People received information about the provider's complaints procedures when they began receiving a service. People's complaints were responded to in writing within the timeframe stipulated in the provider's policy. Responses included the outcomes of investigations. Where it had been necessary information was shared with local authorities.

The provider gathered people's views. People were asked to share their experience of their care and support during quality monitoring visits, phone calls and surveys. The provider reviewed and evaluated the information it received and used it to inform how it planned care and support.

Good

Is the service well-led?

Our findings

At the time of the inspection the service had a registered manager. The registered manager was a qualified social worker who undertook the training required to maintain their registration with the Healthcare Professionals Council. Staff said they felt supported by the registered manager. One member of staff told us, "I have learned so much from my manager. I have really grown in confidence". Another member of staff said, "I value the clarity of her advice. It's the type that is obvious but only after it has been said."

People and staff knew the manager and shared the view that she was open and approachable. One person told us, "I can talk to her anytime. It's fine." A member of staff told us, "She [the registered manager] phones each week and asks how people are and how I am." Another member of staff said, "The manager is very open in terms of their time and welcoming new ideas." Staff told us they were happy in their work. One member of staff told us, "I love my job, it's a great challenge".

Staff understood their roles and responsibilities along with those of the care coordinators and the registered manager. The registered manager understood their responsibilities of registration with CQC and had notified us of important events affecting the service.

The quality of care and support people received was subject to quality monitoring. The manager and coordinators undertook monthly monitoring. Monitoring records showed that managers asked people questions such as, "Did staff arrive on time and stay for the correct amount of time" and "Do staff bring guests or pets to your home." All of the people asked responded "no" to the latter two questions. Managers undertook unannounced spot checks. One member of staff told us, "The manager and director regularly turn up [at people's homes] to do their checks. I don't know they are coming. They are already there [when I arrive]. They talk to people, read the log books, check the medicines records and watch me work. They give me feedback too." Where concerns were identified these were addressed in supervision and, where necessary, staff were given additional training.

The registered manager regularly reviewed care records to ensure they contained accurate, up to date information and continued to reflect people's preferences. Accidents and incidents were analysed to identify causes and prevent any recurrence.

The registered manager worked closely with other agencies to promote positive outcomes for people. Office staff regularly sought advice from health and social care professionals to ensure people's needs were met. For example, following referrals staff worked with social workers and community nurses to plan and deliver care and support to people.