Sugarman Health and Wellbeing Limited

Sugarman Health and Wellbeing - Leeds

Inspection report

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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

We inspected Sugarman Health and Wellbeing - Leeds on 2 and 3 November 2017. The inspection was announced. The provider was given 48 hours' notice of our inspection because we needed to make sure someone would be in the office when we visited. The inspection was carried out by one adult social care inspector.

Sugarman Health and Wellbeing – Leeds is a domiciliary care agency. It provides personal care to people living in their own homes in the community.

Not everyone using Sugarman Health and Wellbeing – Leeds received a regulated activity; the Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene, medicines and eating. However, we do also take into account any wider social care provided.

There was a registered manager at the service. 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.

Medicines were not always managed effectively. Although medicines were managed well overall, protocols for 'as required' or PRN medicines were not in place. Staff were well trained, and the service regularly monitored medicines administration through spot checks and reviews of medicine administration records.

We have made a recommendation about the management of medicines.

There were enough staff to look after people, and staff were recruited safely. This meant that people were protected from individuals who might not be suitable to care for vulnerable adults.

Staff received training in relation to vulnerable adults, and were confident in describing how they would identify abuse and protect people from harm. The service made appropriate notifications to CQC and the local safeguarding team.

Staff received good support through induction, training and supervision. The service regularly monitored training needs and compliance and also provided bespoke training for staff to care for people with specific needs.

People were supported to eat and drink enough to maintain a healthy lifestyle and people's nutritional intake was monitored effectively where necessary.

People were cared for by kind and attentive staff who knew how to respect people's privacy and dignity.

There was a complaints process in place and people we spoke with told us they were confident they knew how to make a complaint if necessary.

Staff told us they felt well supported by the registered manager and that they were confident they would be able to raise any concerns they had in their work. Staff told us they would recommend the service to others as a place to work and to receive care. Staff had regular peer support meetings, however staff did not generally engage with staff surveys that were sent by the provider.

The service effectively monitored the quality of the service they provided through audits and spot checks, and where necessary actions were approved and carried out to improve standards.

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 always safe.

Medicines were managed safely overall, however the service did not follow best practice guidance regarding 'as required' (PRN) medicines.

There were enough staff to care for people and staff were recruited in a safe way.

Risks to people and staff were assessed appropriately and reviewed regularly.

Is the service effective?

Good

The service was effective.

People told us they were cared for by staff who were competent and adequately trained to fulfil their roles.

Staff received an effective induction, mandatory training relevant to their work and were supported with supervisions and appraisals. Staff were given additional relevant training in order to support people with specific needs.

People were supported to maintain good health by staff who assisted with and monitored their nutrition and hydration effectively.

Is the service caring?

Good

The service was caring.

People were cared for by kind and compassionate staff who knew how people wanted to receive their care.

Staff were aware of the importance of maintaining people's privacy and dignity when delivering care and were able to describe how they would respect these.

The service gave due consideration to people's protected characteristics such as their religious and cultural needs.

Is the service responsive?

Good

The service was responsive.

Care plans were written in a person centred way with good detailed guides for staff on how people wanted to be cared for.

Care plans were regularly reviewed in partnership with people and their loved ones.

There was a complaints process in place and people told us they were confident they knew how to raise any issues they might have.

Is the service well-led?

Good

The service was well-led.

Staff told us they felt confident in the leadership of the service and enjoyed their work.

The registered manager was well supported by the provider and the quality of the service was monitored effectively.

The service gathered feedback from people through an annual survey, and people said they were confident the registered manager would listen to their concerns.

Sugarman Health and Wellbeing - Leeds

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 checked 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 2 and 3 November 2017 and was announced. We gave the service 48 hours' notice of the inspection visit because we needed to ensure someone would be in the office.

The inspection was conducted by an adult social care inspector. At the time of the inspection there were eight people who used the service. We spoke with three relatives of people who use the service over the telephone and conducted a home visit where we spoke with one person who used the service and their relative.

We spoke with six members of staff, including the registered manager, clinical lead and care staff. We also spoke with a health professional in the community who had interactions with the service. We reviewed three recruitment files and four care records as well as policies and procedures relevant to people's care.

Before our inspection we reviewed all information we held about the service, including notifications to CQC and the provider's registration certificate. We contacted the local authority for any feedback on the service. The provider also completed a Provider Information Return (PIR). The PIR is a document which asks providers to give key information about the service, what it does well and what improvements they intend to make.

Requires Improvement

Is the service safe?

Our findings

We reviewed the systems and processes in place for managing medicines and found this was not always safe. Overall, medicines were managed well. Staff had been given medicines training and people's medicine support plans included personalised details about what medicines they took, what allergies they had, what their medical history was and how staff should support people take their medicines. We saw that minor recording issues in Medicine Administration Records (MARs) were picked up by regular auditing of MARs. We saw evidence that staff had been asked to explain why they had made mistakes and that they were given extra support and training to help improve record keeping. We did not identify recording errors in the MARs we looked at.

However, medicines that were directed to be taken 'as required' (PRN) were not recorded correctly in line with best practice. For example, we found one person was prescribed paracetamol and the MAR did not specify that it was PRN and included information that it was to be given four times a day; however this was not recorded as being given four times a day because staff understood the medicine was to be given 'as required'. Furthermore, the time of administration was not recorded, which is recommended practice. This is important because paracetamol must be given at intervals of at least four hours to prevent overdose. The service's medicines policy also stated that medicines to be given 'as required' cannot be administered by staff unless there is a specific reason for that medicine to be given. We did not find in people's care plans any information that told staff why a person was being given the PRN medicine. We reviewed another person's care plan and MAR and found the same issue.

We raised this with the clinical lead who immediately contacted the pharmacist to provide new MARs with more information on PRN medicines for each person who had them. They told us they would raise this with the provider and with other services operated by the provider as a learning point. We did not see any evidence of harm as a result and there were no medicine overdoses or incidents recorded.

We recommend the provider consider relevant national guidance on PRN protocol medicines.

Relative's we spoke with said they felt safe having their loved ones cared for by staff. One relative said, "I feel safe, I can go out knowing [person name] is totally safe. We have a key safe, and only regular staff have access."

There were appropriate safeguarding procedures in place and staff told us they were confident they knew how to identify abuse and respond appropriately. One staff member said, "Anything, if I was suspicious of abuse, staff weren't doing what they should be or any issues from the family such as financial abuse. I would also say if I thought management weren't acting appropriately, that also counts." There was an anonymous whistleblowing landline staff could call if they felt they could not escalate a concern to the registered manager. One staff member said, "I'm aware if the manager didn't deal with the issue we would phone the anonymous line." Staff received mandatory training in safeguarding vulnerable adults, which was repeated every year.

There were enough staff to meet people's needs. Care packages were planned in response to people's needs, and staff were recruited based on how many of them were required to meet those needs. One staff member said, "We are not understaffed at all, but are good with each other. We swap shifts and work as a team." One relative we spoke with said, "It's never been a problem getting staff as they are never on sick and are always regular. If they are on leave, others come for extra hours and so we are never let down." There was also a 'check in' calls team which called carers to make sure they were on time or if there would be any delays. Care plans were reviewed regularly, and these included conversations with people and their families to see if the number of staff was sufficient. In one example we saw that a staff member had been taken away from the package because the person did not need as much support.

Staff were recruited safely. We reviewed three recruitment files and found they included a thorough interview record, professional references, relevant qualifications, photo identification and additional right to work checks where necessary. Staff were not allowed to begin work without a valid Disclosure and Barring Service (DBS) check. The DBS is a national agency, which provides information from the Police National Database about any convictions, cautions, warnings or reprimands. It helps employers make safer recruitment decisions that would prevent unsuitable staff from working with vulnerable people.

Care plans included detailed risk assessments for staff and people to ensure that risk could be minimised and safety promoted. Each person had a comprehensive environmental risk assessment for their home, which included information on people's utilities suppliers, accessibility, power outlets and included actions to mitigate risks. For example, where one person was identified as a smoker, an additional fire safety risk assessment had been carried out by the fire service. People had equipment risk assessments for their specialised equipment such as wheelchairs and hoists. The risk assessments included the model, ID number, inspection dates and manufacturer contact details. There was also a business continuity plan in place which gave clear instructions to staff in the event of a significant disruption to the business such as a loss of computer access or natural disaster.

Accidents and incidents were logged and investigated appropriately. There were three accidents and incidents logged in 2017. The incident reports documented details of what occurred, any injuries sustained, if there had been any previously similar incidents and what actions were taken. We saw that in one incident, the person's social worker had been contacted as a consequence and a meeting held to determine how to mitigate future incidents happening. We found that appropriate actions had been taken to ensure people were safe.

Good

Is the service effective?

Our findings

People were supported by competent staff who knew how to carry out their roles effectively. Relatives of people who used the service told us they were confident staff were appropriately trained to care for their loved ones.

New staff received an induction after passing their interview successfully. There was also a six month probationary period where staff who did not meet the standard could have their probation extended or their employment terminated if they did not meet the standards agreed. Staff were required to read a staff handbook, which contained information on what standards were expected of them, corporate values and further information on processes such as safeguarding and whistleblowing.
Staff completed a mix of face to face and online mandatory training before being introduced to the people they were going to care for by senior staff. They also completed shadowing shifts. Overall there were 15 training modules for staff to take. These included fire safety, moving and handling, equality and diversity and basic life support. Staff told us they felt this was adequate for them to complete their roles. Staff told us they also completed training which was tailored around the person they cared for, for example, one staff member told us that because the person they were looking after suffered from epilepsy, they had attended additional epilepsy training. The service also used a training matrix to track what training staff had received and when certain courses were due for renewal.

Staff were also required to pass additional competency assessments on specialised equipment and techniques relevant to the people they supported, for example with PEG feeds [surgically implanted tubes used to directly feed medicines and nutrients into people's stomachs when they cannot swallow] and tracheostomy care. Where relevant, all competency assessments were conducted by the clinical lead and were held in staff files. One staff member said, "Yes I've had a competency assessment, we did an emergency scenario with the PEG feed."
Where people needed tracheostomy or PEG feed care, information about what equipment was used, what it was for and a guide on how to make sure the person was to be supported to live with these interventions was included in their care plans. There were also contact details for specialist health professionals should advice be needed. In one person's care plan where a nurse from another care organisation provided medicines through a PEG feed, the nurse wrote notes for and guided staff on what support was necessary when they started their shift so they were informed of any changes in advance.

Staff were supported with regular supervisions and appraisals. Staff were able to discuss any personal issues, reflect on their performance and identify areas where they might need support, for example any additional training needs. One staff member said, "It's a good opportunity; if I needed it, I wouldn't be afraid to ask if I needed support, but we just to get on with it." Another staff member said about supervision, "We talk about concerns and anything we need. It's useful."

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. Where people live in their own homes, applications to deprive people of their liberty must be made to the Court of Protection.

We checked whether the service was operating within the principles of the MCA. Staff had an understanding of the MCA and DoLS. One staff member said, "It's around people's level of understanding and giving them choice, supporting them to make decisions safely for themselves." The registered manager said, "It's about whether a person has the capacity to make decisions and supporting them with positive choices. We have a good mix of clients and we are supported by social workers and other professionals." We saw that people were asked to sign a consent form to receive care and treatment from staff. We saw that one person did not have capacity and their social worker had applied for a Court of Protection Order which was included in their care plan. Documents from the social worker who had taken the lead on the capacity assessment were also available.. One member of staff said, "The MCA assessments were done at the beginning with social workers."

People were supported to maintain good health by eating and drinking regularly. Where people required monitoring of their nutritional and fluid intake, this was assessed appropriately through fluid charts, as well as a record of what people had eaten. Care plans included detailed information about people's dietary preferences and whether or not they required culturally appropriate diets. In one person's care plan we saw written: '[Name] enjoys hearty traditional meals; his favourites are Sunday lunch and shepherd's pie. He enjoys tea and fruit cordial, and takes a capped bottle to bed, which helps avoid spillages.' Furthermore, where people had been assessed by an NHS dietician, care plans included detailed information about the calorie content of different foods and a plan of how much of each type of food should be offered to ensure the person's nutritional needs were adequately met.

People were appropriately supported to access healthcare professionals. We spoke to a community health professional who told us that they had no concerns with regards to staff competency and that staff made appropriate referrals for medical concerns. They said, "They provide good care and work with the client's mum, they do the best they can for the client. I haven't had any issues." Care plans included a clear timeline of medical concerns, referrals and actions which were included in updated care plans. For example, in one person's care plan we saw how a fall had led to an assessment by a physiotherapist and a discussion held with the person about their fears of this happening again.

Good

Is the service caring?

Our findings

People's relatives told us their loved ones were cared for by kind and compassionate staff. One relative said, "They are totally caring. They love [person's name] to bits. We bought a speaker and staff set it up and put on the music they like and had a dance with her. It's amazing what they do. They are like our family." Another relative said, "They are really good and respectful. They are really nice people. They are very friendly."

We attended a home visit and saw that staff were warm and kind to the person they were looking after. This included gentle reassurance, holding their hand and getting down to their eye level when talking to them.

Staff showed us a document they had created for new staff member who might be shadowing them. It had pictures of the person and what was important to them, including photos of their favourite things and their favourite snacks. We asked staff to describe how they were caring towards the person they looked after and one staff member said, "The care we deliver is all on her terms. [Name] might want affection on Monday and you give it to her, putting arms round her. Then the next day she lets you know she doesn't want you to so you move on to the next thing. It's all on what she wants."

People's privacy and dignity was upheld by staff who were considerate and discreet. We asked staff how they would protect people's privacy and dignity. One member of staff said, "We always close doors in bathroom visits and put a towel over them when washing." Another member of staff said, "We deliver personal care indoors anyway so we make sure the curtains are always closed. If the person is using the toilet we assist them to the bathroom and leave the room until they let us know they are done." Care plans emphasised the importance of respecting people's dignity and privacy, for example, in one person's care plan for washing and bathing it was noted that, 'it is important dignity is preserved at all times when helping them dress.'

Staff completed equality diversity and human rights training as part of their mandatory training programme. The service user group did not include anybody with specific religious, cultural or sexual orientation needs, however the manager was able to describe how they would approach a new client who had specific needs from previous experience. Assessment documents and personal histories discussed what was important to people and how staff would support them, for example if they required a special diet, the manager told us that from this information they would tailor the care package to support them appropriately, for example staff with a similar cultural background would be suggested, and other staff would be informed of any specific considerations needed when delivering care such as dietary and hygiene preferences.

The registered manager and staff we spoke with knew which people had advocates, and there was information on how to access an advocate in people's welcome pack. An advocate is someone who supports people to ensure their views are heard on things that are important to them. We saw that advocates were included where necessary in decisions about people's care. In one case we saw a person had an activities advocate and staff told us they took directions from them on what activities to try.

Good

Is the service responsive?

Our findings

People who used the service and their loved ones told us staff listened to them and were responsive to their needs. One relative said, "They always ask my input. We work together. They tell us about and discuss if there are medical concerns for example." A person said, "If I needed to change anything, I'd ring the care coordinator, as he's lovely."

We reviewed four care plans and found that they were written in a person-centred way. Care plans included a 'Who I am' document which gave an introduction to the person, their life history and what was important to them. For example, in one person's 'Important things to know about me' section, it was written, 'I have a dog called [name], I like to walk her holding onto her lead while staff push my wheelchair'. Care plans included detailed, personalised guides for staff on how to care for people. For example, in one person's care plan, staff had created a photographic guide on how to help a person into their harness so they could travel by car safely.

Care plans were regularly reviewed with people and their relatives. People with high dependency were reviewed monthly and people with lower dependency were reviewed three times a year. The review included staffing levels and the length of visits, social support, changes to their support network, personal care, medical care and diet. People and their representatives signed the document, and it was clear that the person's wishes directed any changes to the care plan. One relative said, "I don't write things down in the care plan that I do personally, but I take note of the plans and they are always filled in correctly. They are good."

Staff recorded what care they provided in people's daily notes. They showed that care was delivered according to the guidelines set out in the care plan. Daily notes were reviewed by the clinical lead, which gave staff suggestions for how to improve their note taking, such as expanding on certain issues like recording the exact food the person had. We saw that these suggestions were followed by staff.

People were supported to participate in activities with staff support if they wanted. Activities were logged in a diary which included the time, date and location of the activity.

There was a complaints policy with guidance for dealing with complaints. This clearly stated that staff must respond within ten working days to any complaint and carry out an appropriate investigation. There were no complaints registered with the service. Care plans included a pack with information on key contacts such as the registered manager and clinical lead, as well as information on how to make a complaint. People we spoke with told us they knew how to make a complaint. One relative said, "Yes there is a complaints process, but I've never had to make a complaint.

Staff recorded compliments from people and their relatives who used the service. One compliment read, "Thank you for your care. [Name] had a happy end of life and a peaceful passing away."

Good

Is the service well-led?

Our findings

Staff told us they felt well supported by the registered manager. One staff member said, "The manager is very approachable. Quite hands-off leadership, so it's like we are running the package. I think it's a good thing as we know our client best. What adds to the positivity is that he is there if we need him. I've been on the telephone for hours with him when I've needed something." Another staff member said, "Yes, the manager is approachable. I feel I have confidence in him."

Staff told us they enjoyed their jobs. One staff member said, "I love my job and I worry about if any of us ever left. There is good team morale." Staff also told us they would recommend the service to their loved ones, both to work for and as a place to receive care.

The registered manager told us they felt well supported by the provider. They attended monthly meetings with other registered managers and these meetings included protected time to discuss issues with the quality lead for the provider. Registered managers also discussed any concerns in compliance, performance of the business and any relevant changes in legislation which might have an impact on care. Performance in quality measures such as training compliance was also discussed and learning from the best performing services was shared.

The service had a robust quality assurance process, which included audits, reviews and spot checks on staff. Audits included checks on MARs, care plans and daily diary notes. We saw evidence that staff were given feedback and support where a concern was identified. For example, in a medicines audit we reviewed it was recorded that each member of staff who had made minor errors in medicines records were talked to and offered support. The registered manager told us, "I get a weekly compliance overview email, and if there is training out of date for example we are asked to give an explanation."
There was also a regular bimonthly quality review conducted by the quality and compliance lead which looked at the quality of audits, training, care plans and staff suitability to work [which made sure staff had the right to work in the UK and had a valid DBS number]. Findings were passed to the registered manager with actions to take. The provider also compared findings with other services to see which service needed support in specific areas to encourage continuous improvement. One staff member said, "I've been spot checked. The clinical lead observed me giving care and she gave me feedback. There weren't any concerns raised." Spot checks were included in staff personnel files.

The service sent a staff survey to gather their feedback, however only 2% of staff responded. Staff we spoke with told us they did not know about the survey or did not have the time available to complete it. Staff had regular peer group meetings where they discussed the person they were looking after and any issues they wanted to raise. Staff told us there were open meetings where all staff had an opportunity to contribute and receive feedback from senior staff.

The service sent an annual survey to people, which included questions on punctuality of staff, continuity of care, staff skills, and dignity and respect. Of the people who responded, 71% said they were 'very happy' with their care and the remaining 29% were 'happy' with their care, with no negative responses. The service

performed better than the other services run by the provider in all response categories. One response read, "Thank you for the continued support, being so kind and making sure I have the same helpers consistently. Thank you for being so flexible."