Mrs O's Caring Hands Homecare Limited

Blyth Community Enterprise Centre

Inspection report

Ridley Street
Blyth
Northumberland
NE24 3AG

Tel: 07834171060

Date of inspection visit:
07 November 2017
08 November 2017

Date of publication:
21 December 2017

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 7 and 8 November 2017 and was announced. This meant we gave the provider notice of our intended visit to ensure someone would be available in the office to meet us. This was our first inspection of Blyth Community Enterprise Centre, also known as Mrs O's Caring Hands.

Mrs O's Caring Hands is a domiciliary care provider based in the Blyth, providing personal care to people in their own homes in the local area. At the time of our inspection the service provided personal care to 21 people, the majority of whom required help to maintain their independence at home.

The service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had extensive experience of working in the social care sector, as did their training manager, who supported them in the running of the service.

People who used the service told us they felt safe and relatives, along with external professionals, expressed no concerns regarding safety. Staff had received safeguarding training and were confident in how to identify and report potential sources of abuse.

Risk assessments were in place to ensure people were protected against a range of harms. These were sufficiently detailed and regularly reviewed and staff displayed a good knowledge of the risks people faced.

Pre-employment checks of staff were in place to protect against the risk of unsuitable people being employed.

A lone worker policy and procedures were in place, with an out-of-hours contact telephone number and personal attack alarms provided.

Medicines administration was regularly audited and staff were trained appropriately; we found no evidence of medication errors. The medication policy and safeguarding required updating and the registered manager did this the day after our inspection.

There were sufficient staff, effectively deployed, to meet people's needs safely, with travel time included in the planning of care calls.

Staff were trained in core areas such as first aid, person-centred care, moving and handling, safeguarding and dementia. Additional training was provided where required.

Staff had a good knowledge of people's likes, dislikes, preferences, mobility and communicative needs. People who used the service confirmed staff knew them well.

People who used the service were supported to maintain their independence in their own homes, in line with the service's literature.

Care plans were sufficiently detailed and person-centred. They gave staff relevant background information and detailed care information about people, meaning care was individualised.

Care plans were reviewed regularly and with the involvement of people who used the service and their relatives.

Staff displayed a good understanding of capacity and the need for consent on a decision-specific basis. People confirmed their consent was sought at each care visit. 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.

People we spoke with and relatives told us they had received positive outcomes when suggesting changes or raising queries, for instance requesting a specific carer or changing a call time.

People told us they knew who to contact if they had concerns and the provider's complaints policy was readily available in the files people had in their home.
We saw there were a range of audits and other quality checks to identify errors, inconsistencies, or scope for improvement.

Staff, people who used the service, relatives and other professionals were in agreement that the registered manager led the service well. We found them to have a good knowledge of the needs of people who used the service, and had a clear vision for how the service could grow in the future, whilst maintain good standards of care for people who used the service.

The registered manager, training manager and staff had successfully established a caring culture, where care could be delivered in a calm, patient manner that had regard to people's individualities.

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.

Risk assessments were in place for each person and described how staff could help people avoid different types of harm.

Pre-employment checks ensured the risk of unsuitable people working with vulnerable adults was reduced.

Medicines administration was well scrutinised by senior staff and people who used the service had experienced no concerns in this regard. Where policies required updating the registered manager was response to external advice.

Is the service effective?

Good

The service was effective.

Staff received a range of initial and ongoing training, as well as a three day induction and shadowing opportunities.

Care visits were well planned, factoring in travel time. This minimised late visits, as confirmed by people who used the service.

People's healthcare needs were met through the involvement of external healthcare professionals, with whom staff liaised with well.

Is the service caring?

Good

The service was caring.

People were treated with patience, dignity and respect by staff who knew them well, in line with the company's philosophy of care.

People were involved in the planning and review of their own care and confirmed they felt enabled by staff.

The individualities and rights of people who used the service, and staff, were respected by the registered manager.

Is the service responsive?

Good

The service was responsive.

Care plans were reviewed by the registered manager or training manager and families confirmed they were involved in these reviews.

Where people's needs changed, staff identified this and sought external support where appropriate.

People who used the service and others knew how to raise concerns if they needed, and the service was open to queries or complaints as a means of learning.

Is the service well-led?

Good

The service was well-led.

People and relatives we spoke with were positive about the accountability and approachability of the registered manager.

Regular auditing was in place to scrutinise standards and to ensure errors were identified and rectified.

The registered manager had taken steps to ensure the service was well prepared to grow, for instance by appointing new team leaders.

Blyth Community Enterprise Centre

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.

We visited the service on 7 and 8 November 2017 and our inspection was announced. The inspection team consisted of one adult social care inspector and one expert by experience. An expert by experience is a person who had personal experience of using or caring for someone who used this type of care service.

Before our inspection we reviewed all the information we held about the service, including previous inspection reports. We also examined notifications received by the Care Quality Commission. We contacted the local authority safeguarding and commissioning teams and Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

We visited the office and spoke with the registered manager, the training manager, the administration officer and three care staff. We spoke with three people who used the service and seven relatives over the telephone. We also spoke with three external health and social care professionals.

During the inspection visit we looked at five people's care plans, risk assessments, staff training and recruitment documentation, a selection of the service's policies and procedures, the electronic call monitoring system, meeting minutes and the service's IT systems.

Good

Is the service safe?

Our findings

People who used the service consistently told us they felt safe in the presence of staff and that their needs were met safely. One person said, "They are all lovely – nothing's a bother." One relative told us, "We haven't had any concerns – they have all been very nice."

External professionals we spoke with similarly raised no concerns about the safety of the service and expressed confidence in how staff promptly raised any questions they had to ensure problems did not develop. One said, "It's a nice little service and there have never been any major issues."

We saw there had only been one missed call since the service started providing care. The registered manager had apologised in person and given the person a bouquet of flowers as an apology. We saw staff care visits were managed and tracked via an electronic call monitoring system, which alerted office staff when staff had not confirmed their arrival and departure at a person's house. This meant the risk of missed or late calls was well managed, and also that office staff had regard to the personal safety of care staff who were often lone workers. In this regard we saw there was an appropriate lone worker policy and that staff were supported with the provision of, for example, personal attack alarms.

There were sufficient staff appropriately deployed to ensure people's needs were met and they were not at risk of harm. People and their relatives confirmed they knew which carers were due to attend and that they had not experienced late or missed calls. One relative said, "If they get held up they let us know but they always let us know."

The registered manager and training manager displayed a good working knowledge and oversight of medicines. We found some aspects of medicines administration to have been updated in line with the most recent guidance from the National Institute for Health and Care Excellence (NICE). For example, where people required medicines 'as and when' we saw there were specific and detailed protocols in place telling staff when the medicine might be required and what effects they should expect.

Appropriate medicines administration training had been delivered and that the training manager had achieved 'train the trainer' status in this regard. Staff competence regarding medicines administration was reviewed as part of spot checks of their conduct on care visits, whilst medicines administration records were gathered from people's houses each month and audited. This meant that people were protected against the risk of the unsafe administration of medicines.

We noted that, whilst some medicines procedures were in line with good practice guidelines, the medication policy had yet to be updated to ensure it was in line with NICE's recent guidance. The registered manager agreed to address this as a priority and provided us with a revised medicines policy the day after the inspection.

Accidents and incidents were recorded. We saw there had been few and that these were minor, although they had been appropriately documented and could be reviewed, should subsequent patterns or trend

emerge.

When we spoke with care staff they demonstrated a good knowledge of safeguarding principles and how they had acted to ensure people were kept safe. They understood their responsibilities and felt well supported to raise any concerns if they had them. Staff consistently expressed confidence in their manager taking seriously any concerns raised and were able to describe how they would whistleblow (tell someone) if they had concerns about the organisation. All staff we spoke with had received safeguarding training as part of their induction. Staff were also supported by way of an out-of-hours telephone number where they could reach a senior member of staff for support if needed.

We reviewed the provider's safeguarding policy and found it was in need of an update. For instance, it did not refer to self-neglect, one of the areas of abuse defined in the Care Act of 2014. The registered manager agreed to review the policy in line with the current best practice including the local authority's over-arching safeguarding policy document.

Staff understanding of the individual risks people faced was good and in line with the personalised risk assessments in each person's care file. When people began using the service we saw assessments were made of people's environment, personal circumstances and needs to establish if they were at particular risk. Actions were then clearly described for staff to help people mitigate these risks. These actions were person-centred and meant visiting staff could better help people to feel less anxious. For example, in one person's care plan there was a detailed description regarding how they liked to get dressed to minimise pain in an old injury. This level of detail meant staff could provide people with individualised care that had regard to people's anxieties.

We reviewed a range of staff records and saw that all staff underwent pre-employment checks including identity checks, references and enhanced Disclosure and Barring Service (DBS) checks. The DBS restrict people from working with vulnerable groups where they may present a risk and also provide employers with criminal history information. Where a historical offence was disclosed we saw this was appropriately risk assessed by the registered manager and control measures in place. This meant that the registered manager ensured the risks of employing unsuitable people were reduced.

With regard to infection control we saw staff had received relevant training and, when we spoke with people who used the service, they confirmed staff wore gloves and aprons where necessary and that they had no concerns regarding staff ability to maintain hygiene levels.

Good

Is the service effective?

Our findings

People who used the service and their relatives told us they felt staff had the necessary skills and experiences to support them. One relative said, "They all seem well trained" and another said, "They are very professional in what they do." One person told us, "When I first came to the service, many of the carers had not been trained in my requirements of PEG feeding and certain other PEG operations. This was quickly addressed. Otherwise the carers are adequately trained." A PEG (Percutaneous Endoscopic Gastronomy) tube is inserted into a person's stomach when they are unable to eat orally. We saw staff had been trained in this regard to ensure they could meet the person's needs.

Training was delivered to new staff as part of the induction process and on an ongoing basis. We saw the induction included familiarisation with policies, with staff signing to confirm they had read them. Core training included safeguarding, fire safety, dementia awareness, moving and handling, food hygiene and first aid.

The service used a combination of online training courses and face to face training. The training manager planned to deliver refresher training on moving and handling, for which the service had invested in a hoist and slings to give staff practical guidance prior to visiting people who used the service.

The registered manager used the resources available to them to ensure staff received appropriate training opportunities, for example sourcing free training courses from a university and developing in-house expertise.

Shadowing was used effectively to ensure staff clearly understood their roles and the needs of people they would be supporting before working on their own. For example, one new team leader was in the process of completing four weeks of shadowing in their role. People who used the service had seen shadowing in action and felt it was beneficial to them. One person told us, "If a new carer starts they shadow the others until they know what they're doing."

The administration officer showed us the online rota planning and electronic call monitoring system and we found it was well managed. Travel time was factored in and staff were given sufficient time to get from visit to visit.

The National Institute for Health and Care Excellence (NICE) guidance, 'Home care: delivering personal care and practical support to older people living in their own homes (September 2015)' states providers should, "Ensure service contracts allow home care workers enough time to provide a good quality service, including having enough time to talk to the person and their carer, and to have sufficient travel time between appointments." We found the provider acted in line with this guidance and, during the course of the inspection we observed a staff member refuse a request for a care package with 15-minute care visits to administer medicines. The register manager confirmed they only had 15-minute calls in place for calls where the carer needed to check the person's home was secure; no personal care visits were 15 minutes in duration.

When we spoke with people who used the service, the feedback was positive. People confirmed staff stayed as long as was planned on the rota and did not rush. One professional we spoke with confirmed this was their experience too. This meant staff had sufficient time built into the rota to attend each care visit and to ensure people's needs were met in a manner that was patient and not rushed or overly task-focussed.

People's descriptions of how they were involved in the care planning process was consistent with the company's marketing and service user guide literature. One person said, "The manager came out and saw us and did the care plan with us and that's in the house in the folder." We saw each person had a sufficiently detailed pre-assessment of their needs.

In line with the service's literature, people's needs were assessed prior to them using the service, including assessing environmental risks such as trip hazards, electrical equipment and specific mobility considerations. These pre-assessments also considered dietary requirements, medication needs and likes and dislikes. These were documented comprehensively in sections entitled "More About Me," and, "My Life So Far." We found there was a significant amount of relevant background information about each person whose care file we reviewed, whilst care files were easy to follow. This meant carers had access to a good amount of person-centred information and were able to build a rapport with people they were caring for, as well as knowing their basic needs.

People told us staff made them the meals they wanted. A number of people chose microwaveable meals but some people told us how staff were capable and willing to make them a range of meals where they preferred it. On the day of the inspection on person who used the service sent a photograph to the registered manager of the cooked breakfast their carer had made them that morning. Relatives also said, "If we're out we leave something to reheat for them but nothing is too much trouble and they just make something else if they need to," and, "They cook whatever [person] wants really: scrambled eggs or a toastie."

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 saw that staff had been trained on the subject of Mental Capacity as part of their induction and demonstrated a good understanding of presuming people have capacity. People gave consent to the care provision when starting to use the service and confirmed to us that staff asked them for their consent during each care visit.

Care staff told us they enjoyed good working relationships with office staff. One member of staff told us, "Since coming here it's so much better – the manager supports you," whilst another said, "We're lone workers but it does feel like a team." We saw supervisions took place and appraisals were planned. Staff confirmed these were opportunities for meaningful discussions about any concerns they may have, and their professional development. Staff meetings took place regularly.

We saw evidence of regular communication with external healthcare professionals to ensure people's healthcare needs were met.

Good

Is the service caring?

Our findings

People who used the service and their relatives gave us a range of positive feedback about how staff interacted with them, and the positive relationships they had formed with a team of trusted carers. One person who used the service told us, "They are really lovely." Another said, "The carers always show patience and courtesy." Relatives told us, "After they finish they sit in and have a real chat," and, "I like it because they know they need to take their time – my relative gets dizzy of a morning and can't be rushed." Staff members we spoke with confirmed they had sufficient time to not only complete tasks but get to know people. One said, "It's more relaxed – you don't feel rushed and you have enough time to chat with people."

People also told us they generally knew which carer would be visiting, and that they got on well with them. One person said, "I have a main carer who overviews things and who ensures that that my care runs smoothly." The importance of maintaining a continuity of care was highlighted as an area of best practice for domiciliary care providers in guidance issued by the National Institute for Health and Care Excellence (NICE) in their publication, 'Home care: delivering personal care and practical support to older people living in their own homes' (September 2015). We found the service generally ensured people received care from staff they were familiar with over a period of time.

Care plans contained a range of information about people's backgrounds and personal histories, meaning they were written in a person-centred way. Person-centred means ensuring all aspects of care are planned around a person's individual likes, dislikes and the things that make them an individual. For example, how that person would like to be addressed, how much help they required with showering and how staff could ensure their dignity was respected. This level of detail meant staff who read the care plans had a comprehensive introduction to how people wanted their needs to be met.

Staff demonstrated a good knowledge of people's individualities and about how they liked to be supported. People who used the service confirmed staff communicated with them well and were respectful of their needs. One person said, "They are very nice and kind and they chat at my pace."

Care plans were written with the involvement of people who used the service and those who knew them best. Relatives confirmed, for example, "They came out and did a full care plan and really tailor made the service to what we needed. We have the folder here." This meant people were regularly given the opportunity to take as much ownership as they felt comfortable with in the planning and review of their care.

We found some instances of staff going above and beyond what was expected of them in the day-to-day delivery of care. For example, when one person was taken ill and their family were abroad on holiday, staff took the person to hospital. The person's relative told us, "They even went to see them in the hospital on the Saturday and brought them a box of chocolates." Another relative said, "They even vacuum the kitchen floor if [person] has been up in the night having snacks – that's not in any care plan."

The service had received recent compliments which demonstrated people had received a service they were

impressed with, for example, "Thank you so much for the care given to my mum – the carers were kind and helpful," and, "As a family we were very happy with the support and felt reassured that mum was safe."

Staff respected and were sensitive to people's rights to maintain relationships meaningful to them. For example, one person was in a relationship with a person who lived a significant distance away. Staff had helped to arrange for this person to visit them.

We found the caring attitudes of staff were reflective of the provider's approach to delivering care and that individual staff were encouraged to take the time required to ensure people felt cared for. Likewise, the provider respected the needs of staff and ensured they were able to contribute to people receiving positive wellbeing outcomes. For example, one member of staff had come out of retirement to work for the service. They did not drive so the registered manager ensured their rota was aligned to accessible public transport links, meaning they could fully complete their caring role without any additional time. The provider was therefore dedicated to ensuring staff were supported in a way that enabled them to provide good care to people.

People's sensitive personal information was securely held in locked cabinets in the office and computer systems were password protected. The data protection policy was fit for purpose and staff had been trained in this regard.

Good

Is the service responsive?

Our findings

People who used the service and their relatives felt reassured about the level of ongoing support and review they received from the service. One person said, "I have had a good forty minute discussion with [registered manager] about a month after it started and they check up on me regularly."

We saw evidence of regular assessments and reviews being completed and when we spoke with people who used the service and their relatives, they confirmed they were regularly involved in these. One told us, "[Staff member] has been out to see us since it started to check everything and it's easy to get hold of them on the phone."
Staff had formed strong bonds with people who used the service and helped them maintain their independence and personal wellbeing. One carer told us about how they had recently taken one person on an outing to a local park that they had wanted to visit, as well as visiting a railway museum with them. These had been the person's choices and meant they were able to fulfil long-held wishes to return to these places. These outings were planned in the person's care package under the heading of 'enablement'. We saw enablement calls were allocated to people to support them maintain their independence and to remain a part of the local community, for example visiting the local shops or places of interest.

Staff listened to people's preferences and acted on them, displaying a good knowledge, from their taste in war films to how they liked their tea made. People who used the service told us, "They know me well," and, "They are quick to rectify things when they are alerted".

One relative said, "We didn't think our [Relative] was going to make it out of hospital but the service were very accommodating and sorted things out on a Sunday." Staff were sensitive to the needs of people who needed to move between services. The registered manager had developed a hospital admissions record for this purpose. We saw this was regularly updated by staff to ensure it reflected the person's needs, should they need to go to hospital.

People's feedback was that they generally received care visits from staff they got on with well and felt comfortable sharing their interests. People's preference for male or female carers was respected. One relative told us, "When they first came to see us they couldn't take [person] on as we only wanted female carers but a few weeks later they had more staff and could do it, which was great."

Where contact was made with external professionals, for example an occupational therapist or a district nurse, we saw this was clearly documented and updates were incorporated into care planning. Professionals confirmed staff were responsive to people's changing needs. One told us, "One person had been with another care provider and came over. Staff queried a few things and were right to. They take an interest and raise things appropriately." Another healthcare professional told us, "We're happy to use them and they're good at getting back to you at short notice. They're flexible in terms of when hospital appointments change and they do keep us updated if things change." This flexibility was reflected in feedback we received from people who used the service and their relatives. One relative told us, "They come at different times as [Relative] likes to get up early but [Relative] likes to have a lie in."

All people we spoke with and their relatives confirmed they knew how to make a complaint and who they would do this to. We saw each service user file, kept in people's houses, had a clear complaints procedure set out, along with a complaint form ready to submit, should anyone have a concern they wanted to raise. The provider's complaints policy was clear and accessible.

Good

Is the service well-led?

Our findings

At the time of our inspection, the service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. The registered manager had extensive experience of working in adult social care and, along with the training manager, displayed a sound knowledge of the needs of people who used the service. Both managers were able to give examples of how they ensured the service was delivered in line with its principles and values, as set out in the company's literature. For example, the training manager had sourced a range of external training provision and had ensured they had retained their own accredited trainer status to ensure staff received a suitable array of training. Likewise, the registered manager had attended external events such as CQC's recent information session on best practice guidance on managing medicines in people's home. This demonstrated the service was led by a team who were committed to ensuring staff were appropriately skilled and informed.

The training manager was currently shadowing the registered manager in their role with a view to taking over longer term. They were knowledgeable in all areas we discussed with them and took a lead role in the auditing of medicines and training delivery. The focus on adequate shadowing was a theme of the inspection, with the training manager shadowing the registered manager for a number of months and one new member of staff we spoke with having completed four weeks of shadowing. This meant staff had sufficient time to understand their role before working on their own.

The registered manager was able to demonstrate how they were readying the service for prospective future growth. They had recently appointed four team leaders, who would be delegated additional auditing and supervisory roles. One external professional we spoke with told us, "I think they're walking before they can run, which is good."

Auditing and supervisions/appraisals were currently undertaken by the registered manager and training manager and we found these processes to be effective in scrutinising, for example, completed care records and completed medicines administration documents. Spot checks were also undertaken of staff to ensure they conducted themselves professionally and met people's needs.

When we identified that the safeguarding policy and medicines policy were in need of review, the registered manager completed this promptly. They demonstrated that they had previously sought external advice on the medicines policy and were awaiting feedback at the time of inspection.

The registered manager was well respected within the organisation and by the professionals we spoke with. They had been nominated for a 'Putting People First' award at the Great British Care Awards at the time of inspection.

The majority of people who used the service we spoke with confirmed they knew who the registered manager was, or another senior member of staff, and that they had regular contact from the management team. One person said, "They have made sure things have gone well," whilst relatives told us, "We have fallen on our feet – this company is so much better than the other unreliable service we used before," and,

"There have been one or two things I have had to say to [registered manager], nothing serious like, and she has been on it straight away and it's resolved, so I have no worries."

The registered manager and training manager demonstrated they were keen to change and innovate to continue to provide high standards of care, for example trialling new paperwork such as the medicines audit or the hospital information form. Likewise, they had recently agree an additional on-call pay rate for one member of staff with a 4x4 vehicle to ensure they were better prepared to get staff to people's homes if the winter brought adverse weather.

We found staff to have a consistent understanding of the policies relevant to their roles and saw the registered manager reviewed and updated policies regularly in line with local and national guidance and good practice.

The culture of the service was one of respecting people's individual choices and ensuring staff had time to make them feel comfortable. All staff we spoke with were consistent in their descriptions of the support they received and that they were never pressured to treat care visits as task-orientated. Staff were consistent in their description of the registered manager as a supportive leader. One told us, "They bend over backwards to help you," whilst another said, "It's all about caring and they make sure you have enough time to get things done." We found staff morale to be high and there to be a clear team ethic.