Sevacare (UK) Limited

Synergy Homecare - Preston

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 service was registered by CQC on 16 February 2016. This was the service's first inspection since Sevacare (UK) Limited took over the service and had registered with the Care Quality Commission at this location. At the time of this inspection the service was providing support to people living in Preston. Synergy provides support with personal care, domestic tasks and shopping to people living in their own homes. This inspection took place on 19 and 20 September 2017 and the provider was given 48 hours notice of the inspection in accordance with our current methodology for the inspection of domiciliary care agencies.

At the time of our inspection, the service did not have a registered manager in place. The previously registered manager had recently de-registered with the CQC, and the new manager was in the processing of applying for registration with the CQC. A registered manager (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.

The feedback we received from people using the service and their relatives was very positive. People told us they were very satisfied with the standards of care and support they received. They described how they enjoyed good working relationships with care staff and they were treated with dignity and respect.

People were supported in their own homes by well-trained staff that were able to meet people's needs safely. Staff were appropriately and robustly recruited to check their suitability. There was sufficient staffing capacity to ensure people received safe, consistent care.

Good support was given to people to maintain their health and, where needed, to meet their dietary requirements. There were good working relationships developed with health and social care professional to meet these needs. Suitable arrangements were made to safely assist people in taking their prescribed medicines. However, we noted that medicine records were not always completed correctly, and have made a recommendation about improvements needed to medicine records.

People received person centred care in line with their individual needs and preferences. Care planning was focused on the wellbeing of the individual, how they preferred to be supported and the outcomes they wished to achieve. There was a clear commitment to support people in a way that promoted their independence.

We found the service had established effective systems to protect people from abuse and respond to any safeguarding concerns. Risks to personal safety had been assessed and measures were in place to prevent people from being harmed.

The registered provider had a procedure for receiving and managing complaints. The new manager and provider demonstrated a good understanding of the importance of effective quality assurance systems in

promoting the quality of the service. The new manager promoted an open, inclusive culture and provided leadership to the staff team. Staff were proud to work for the organisation.

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 enough staff to provide the support people required. Robust systems were in place to check that new staff were suitable to work in people's homes.

The care staff and managers in the service took appropriate action to protect people from the risk of abuse and to keep people safe.

Suitable arrangements were made to safely assist people in taking their prescribed medicines."

Is the service effective?

Good

The service was effective.

Care staff were trained and supported to ensure they had the skills and knowledge to provide the support people needed.

People received the support they needed with the preparation of their meals and drinks.

People were well supported to maintain good health. Staff were aware of people's healthcare needs and where appropriate worked with other professionals to promote and improve people's health and wellbeing.

People's capacity was always assessed in line with the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

People were supported by staff who were very caring, kind and friendly. They were asked for their views and the choices they made were respected.

The staff knew people well. They gave people time to carry out tasks themselves and understood the importance of supporting

people's independence.

Is the service responsive?

Good

The service was effective.

Care plans were sufficiently detailed and person centred and people's abilities and preferences were clearly recorded.

People made choices about their lives and were included in decisions about their support.

The registered provider had an appropriate and responsive procedure for receiving and managing complaints.

Is the service well-led?

Good

The service was well-led.

Although the service did not have registered manager in place, the new manager, who was experienced and well trained, was going through the application process to be registered with the CQC.

People using the service, their relatives and staff were positive about the new manager's running of the service.

People were asked for their views about the service and knew how to contact a member of the management team if they needed.

The provider set high standards and monitored the quality of the service to ensure these were maintained.

Synergy Homecare - Preston

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social are 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.

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The inspection was carried out by one adult social care inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using domiciliary care, and caring for older people in their own homes.

Before our inspection a Provider Information Return (PIR) was requested from the provider, and reviewed the information they supplied to us. A PIR provides key information about the service, what it does well and improvements that are planned to be made. We reviewed all of the information that we held about the service including statutory notifications that the provider had sent us. In addition, we sought feedback from the local safeguarding adults team, the contracts and commissioning team and health care professionals about the service. We used all of the information we had gathered to inform the planning of our inspection.

A range of different methods were used to gather information and feedback about the service. We reviewed the provider's annual survey for people using the service. We talked with seven people, three relatives, the new manager and fourteen care workers. We examined five people's care plans, staff recruitment, training and supervision records, and reviewed other records related to the management and quality of the service.

Good

Is the service safe?

Our findings

People told us they felt safe using the service. Relatives also told us they thought the service was safe. Comments included, "They [staff] look after me, nothing is too much trouble" and "I trust them [staff] they are really good." One person said, "We've had a few problems in the past with lateness, and that can make you feel a bit uneasy. But the carers normally ring to say that are stuck in traffic, or delayed for some reasons. The issue of lateness has got better recently, and I feel a lot more secure, because I know that people will arrive at a set time, give or take a few minutes."

Staff understood their roles and responsibilities in regards to safeguarding people from abuse. We found evidence to show that they had received appropriate safeguarding training, and they were able to how this training was put into practice. The new manager and staff was aware of how to make safeguarding referrals where appropriate, and had access to guidance on safeguarding adults, and how to liaise with the local authority to ensure risks to people's health and safety were dealt with.

We found evidence to show that risk assessments had been carried out and risks to people's physical, mental health and environment had been considered. For example, the risk assessments took into account people's mental health, mobility and how prone they were to falls, their medicine requirements, their behaviours, their living environment and any equipment used at home. We saw that these documents were reviewed when people's needs changed, and these changes were recorded so that staff could meet people's up to date needs. Staff were made aware of any changes either via a telephone call, via a text message or a face to face with the service coordinators For example, one person who had not previously needed support to use the shower, now needed assistance. Their risk assessment and support plan had been updated, and this had been communicated to the staff.

A wide range of safety policies and procedures were available at the agency office. For example, staff we spoke with were aware of what they needed to do in the event of being unable to gain entry to someone's house, who they would expect to be at home, and who to call if they come across problems. Systems were in place for the recording of accidents and incidents experienced by those who used the service. The records showed that these were completed when necessary and appropriate action taken to deal with issues, and make changes to the way care was provided if required.

The service had sufficient staff to meet people's needs. The new manager told us that they monitored how many staff were needed to meet people's needs, and if changes were needed then a review of people's care took place in order to ensure the correct staffing levels were provided. People who used the service said that staff were "flexible and consistent". Three people who we spoke with said that staff were sometime late arriving for appointments.

We spoke to the new manager and nine staff members regarding this, and checked a number of records relating to staff timings and appointments. We found there were times when staff were a few minutes late for appointments, but the records showed that the service coordinators made contact with people to alert them to the fact that staff may be late arriving.

The reasons for this small number of late appointments were staff stuck in traffic jams, road works or delays following the provision of care at other people's houses. We also noted that staff had a 15 minute "travel" time in which to arrive at a person's house. We found that only a very small number of appointments had not been met within this 15 minute "travel" envelope. And, the reasons for these delays were not only communicated to people, but the reasons for the delay.

The acting manager explained that the service had recently acquired a new logging in and out system for staff to use when working in people's homes. The system was found to be an application on a Smartphone, and it allowed staff movements and appointments to be monitored to real time. The new manager said that this would allow staff and coordinators to be in a better position to alert people to delays in appointments. He also added that if staff were going to be very late for an appointment, that either he or a service coordinator would attend the appointment. We saw evidence that this had taken place on a few occasions in recent months.

The staff recruitment files we looked at showed that the service had a clear process in place for the safe recruitment of staff. We saw that staff had completed an application form outlining their previous experience and employment history. Satisfactory references, identification and a Disclosure and Barring Service (DBS) check had been undertaken. The DBS check helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Risk assessments were in place if additional assurances about a person's suitability to work with people in the community were needed.

Systems were in place for the safe administration of people's medicines. We saw documentary evidence to show that the service delivered training in medication awareness to all staff members. The new manager said, "We have a medication policy in place that staff would follow if a new client needed support with medicines. We would carry out the relevant risk assessments associated with medication administering just as we have done with our existing clients."

We found that the policy was comprehensive, and included protocols for monthly audits, error recording and reporting. We noted that the monthly medicine audits had identified that staff regularly failed to sign people's medicine administration records (MARs) after that they either prompted people to take their medicine, or after they administrated topical creams.

The new manager and company medicines auditor had an action plan to tackle this issue through staff training, supervision and potential disciplinary action, as the frequency of errors such as this was very high. We noted that none of the people supported by the service had raised any issues or complaints about medicines administration, and no one raised the issue when we spoke with them. We recommend that the new manager and management team ensure that the guidelines relating to safe administration are carefully followed, and that best practice in this area of care and support is embedded within the service.

The service had an appropriate policy in the control and spread of infections, and staff were provided with basic health and hygiene training. When staff were involved in personal care, they were provided with appropriate personal protective equipment (gloves, aprons), and had access to cleaning materials.

Good

Is the service effective?

Our findings

People received care from staff who knew them well, and had the knowledge and skills to meet their needs. Comments from people and their relatives included, "They [staff] are all seem to be trained to a good level" and "They [staff] know my relative's needs really well, and the staff always seem very knowledgeable about their condition."

We found documentary evidence to show that staff had completed an induction and probation period which equipped them for starting to work with people in the community. This included knowledge of the service's policy and procedures, undertaking training and meeting people who used the service whilst shadowing an experienced staff member. They were then observed in their practice of caring for people and had time to reflect on their performance. Newly recruited staff were supervised until the new manager was confident they could provide appropriate care and they had completed their probation period satisfactorily.

Staff undertook courses on the service's mandatory training programme either classroom or individual learning based. Depending on the subject, these would be either refreshed every one or two years. For staff who did not have a qualification or experience in health and social care, they were encouraged to complete courses linked to the Care Certificate. This is the new vocational qualification for health and social care workers. Staff told us there were good opportunities for on-going training and for obtaining additional qualifications. One care worker said, "Training is good."

Staff personnel records which we saw showed that staff members were regularly observed and assessed during visits to people who used the service. This helped to ensure a satisfactory standard of work performance was maintained. Supervision sessions were documented, which highlighted any areas for improvement, such as medication errors. Action plans were then developed in order to minimise the risk of any reoccurrence.

Annual staff appraisals also took place, during which topics such as aims and objectives, individual roles, specific job descriptions, personal development, medication competency assessments and additional training requirements were discussed and actioned.

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. We checked whether the service was working within the principles of the MCA. We noted that people had signed to consent to care where appropriate. Where people had dementia and could not make a decision staff had guidance about what support needed to be provided.

We looked at the care files of five people who used the service and found that the service was working within the principals of the MCA People had signed to consent to their care arrangements where appropriate. The registered manager told us that they would request consent from people or their authorised representatives in all new reviews and new assessments to ensure they had people's agreement and consent to their care arrangements.

Staff were aware of the MCA and knew how it applied to people living in their own homes. They knew how to support people with decision-making about everyday tasks. Mental capacity assessments had been completed so that staff were aware of people's abilities and capabilities of making decisions day- to- day.

People were supported with food and fluids. Where people required assistance with food and drink, this was detailed in their care plan. Where people's nutritional needs were of concern, their fluid and food intake was recorded so that any weight issues could be monitored. Staff liaised with family members if they had concerns regarding a person's food and fluid intake.

We saw from information in people's files that staff regularly communicated with family members and professionals such as GPs, disability assessment teams and the speech and language team when they had concerns about people's health and wellbeing.

Good

Is the service caring?

Our findings

People received care, as much as possible, from the same care worker or team of care workers. People told us new staff were always introduced to them and didn't work on their own until the staff member and the person were in agreement with this happening.

Comments from people and their relatives included, "I know all the staff who come to help me and new staff are always introduced to me before they work on their own", "I have regular staff" and "They [staff] are professional yet friendly." People told us staff always treated them respectfully and asked them how they wanted their care and support to be provided. People and their relatives spoke well of staff, comments included, "Staff are wonderful. They are marvellous and kind" and "Staff are like my friends."

People who received a service told us they felt their staff had been matched to meet their needs. Other comments from people included, "All the staff are of the same high standard, I can't say one is better than another."

The staff knew people well. They gave people time to carry out tasks themselves and understood the importance of supporting people's independence. The staff had very good knowledge of people's histories, likes and preferences and we saw this attention to detail was built into the practicalities of care provision. For example, one person's care plan had instructions about how the care workers was to present their main meal items, and in which order so as not to create confusion or anxiety. This meant people's independence and choices were promoted, and showed that the views of the person had been listened to and put into practice.

Staff members we spoke with were able to discuss the needs of those in their care well and it was evident that people's cultural backgrounds were respected at all times. People told us that they received support from the same care workers, who they had got to know well and who they trusted.
People said they were always spoken to in a friendly, polite and respectful way.

Staff were considerate and showed respect and protected people's dignity. When we asked one relative about this subject they told us, "Absolutely. The staff always close the door when providing personal care, and always protect my [relative's] modesty." We saw this attention to people's dignity was written into the care planning documentation.

People we spoke with who used the service spoke highly of their care workers. The policies and procedures of the service covered areas such as, privacy and dignity, data protection and the importance of confidentiality. This helped to ensure people's personal information was consistently protected. The plans of care we saw included the importance of respecting people's privacy and dignity, particularly during the provision of personal care.

We saw sensitive personal information was stored securely in locked cabinets within the service's offices. Relatives and people who used the service confirmed their permission was sought before their confidential

information was shared with other healthcare professionals and we saw this documented in care files. This meant people could be assured their sensitive information was treated confidentially, carefully and in line with the Data Protection Act.

Good

Is the service responsive?

Our findings

We found documentary evidence to show that people's needs were assessed, recorded and communicated to the staff effectively. The service user guidelines given to people was well written, clear and easy to read so people and their families knew what the service offered. Information about people and their requirements was discussed during the initial assessment and prior to the service being agreed. Decisions about the service to be provided were made jointly so that the service was tailor made and individual. People in receipt of the service (or their authorised representatives) had signed their agreement to their care arrangements.

We looked at the care files of five people who used the service. Detailed assessments had been conducted by the funding authority before a package of care was arranged and a lot of information around certain medical conditions had been obtained for the staff team. This helped to ensure the management team were confident that staff had the right skills and experience to deliver the care and support people needed. Care plans provided staff with the information they needed to deliver person centred care. For example, the tasks to be undertaken, preferred times, any specialist care and support required were documented.

People's cultural, gender and spiritual needs were identified and met. People were asked their preferences about care being provided by male or female staff. Reviews of people's care were undertaken and identified if a person's needs were changing or increasing and took account of their views and opinions. Any changes needed were added to the care plan at the person's home so that staff were aware of the changes made. Staff kept up to date with recording in and reading the daily notes so they were aware of people's needs at the time of each visit.

People we spoke with told us that care and support was provided in a way which they preferred, with their wishes and choices being consistently respected. The care plans had been developed with the involvement of those who used the service or their relative and their preferences were taken in to consideration. Care staff we spoke with told us they consulted the support plans, in order to obtain up to date information about people's and they were able to discuss the needs of people well, in accordance with the plans of care we saw.

The service had a complaints process in place. We saw the complaints procedure was clearly displayed in the Service User Guidelines. We found that complaints were being well managed. A robust system for the recording of both formal and informal complaints received by the agency was in place. People we spoke with told us they would know how to make a complaint and would feel comfortable in doing so, should the need arise.

Good

Is the service well-led?

Our findings

People and relatives all described the management of the service as open and approachable. Comments included, "I would recommend the service to anyone", "I have confidence and trust in the service and they earned that very quickly" and "They [the management] are open to any comments and feedback."

At the time of our inspection, the service did not have a registered manager in place. The previously registered manager had recently de-registered with the CQC, and the new manager was in the processing of applying for registration with the CQC. The new manager had worked at the service for a number of years, and knew the client group, and staff, very well. The new manager was being supported /mentored by the previously registered manger, and he was seen to carry out his responsibilities in an orderly and effective manner, updating his training and knowledge as required, and was well supported by the service provider.

There was a positive culture within the staff team and staff spoke passionately about their work. Staff received regular support and advice from managers via phone calls, messages on their mobile phones, and face to face individual and group meetings. Staff were complimentary about the management team and how they were supported to carry out their work.

The service gave people and their families questionnaires to complete on an annual basis. Results from a survey carried out in August 2016 showed high satisfaction levels. For example, everyone had answered questions about their overall view of the quality of the service as good or excellent.

There was documentary evidence to show that when people were dissatisfied in a particular area the new manager had taken time to meet with the person, and discuss their concerns, with a view to trying to make improvements. For example, one person was unhappy about the time taken to have a bath, and thought the care worker was rushing. This was discussed with the care worker and positive changes made to the way they worked.

We found that the culture of the service was one entirely geared towards the care provided to people who used the service. This was reflected in the care planning we saw, in discussions with relatives, and through the training and supervision offered to staff.

Documentation we reviewed was accurate, contemporaneous and ordered in such a way that made any auditing or reviews efficient. We saw auditing processes in place to monitor aspects of the service such as risk assessments, care plans, daily logs and reviews. Information held within the care plan reviews showed that the people were very satisfied with the service they received. Feedback about people's experiences of using the service was obtained via the review of their care arrangements, and on a day-to-day basis via telephone calls or visits.

There were effective quality assurance systems in place to help ensure any areas for improvement were identified and action taken to continuously improve the quality of the service provided. The management team monitored the quality of the service provided by regularly speaking with people to ensure they were

happy with the service they received. They worked alongside staff to monitor practice through unannounced spot checks of staff. This helped to assess the quality of the services provided.

There were effective systems to manage staff rosters, match staff skills with people's needs and identify what capacity there was to take on new care packages. This meant that the management team only took on new work if they knew there were the right staff available to meet people's needs.

Although the service did not have a registered manager at the time of our inspection, the new manager had applied to be registered with the CQC, and the service met all the other provider's conditions for registration. The service routinely notified and liaised with CQC and external organisations appropriately.