DCS&D Limited

Heritage Healthcare - Teesside

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 6 and 26 June 2018 and was unannounced. This meant the provider did not know we were coming.

Heritage Healthcare Teesside is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults. At the time of the inspection the service was providing support to 66 people in total.

In 2017 the provider amalgamated two of their locations into one service and registered the location as Heritage Health Care Teesside. This is the first inspection of the new service.

The service did not have a registered manager. The manager of Heritage Healthcare Teesside had previously been employed in one of the provider's other locations. Therefore, was familiar with the systems and processes and was able to support us during the inspection.

'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Not everyone using Heritage Healthcare Teesside receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene, support with medicines and eating. Where they do we also take into account any wider social care provided.

We found gaps in the recording on the medicine administration records. Medicine audits from 2017 – 2018 highlighted issues with staff not always completing MAR charts correctly.

We made a recommendation about medicine recording.

Where commissioners required the service to commence emergency packages of support, staff did not always have written information on how to support the person. Verbal instructions were given to staff prior to care coordinators completing an initial home visit to develop care plans.

Staff were aware of safeguarding processes and knew how to raise concerns if they felt people were at risk of abuse or poor practice. Where lessons could be learnt from safeguarding concerns these were used to improve the service.

Recruitment processes were in place with all necessary checks completed before staff commenced employment.

The provider ensured appropriate health and safety checks were completed to ensure staff were aware of position of gas and electricity meters in case of emergency. The provider had lone working policies in place for the safety of staff.

Staff received regular supervision and an annual appraisal. Staff told us opportunities were available for staff to discuss performance and development. Staff completed mandatory training and followed an induction process which included shadowing experienced staff.

Staff understood the Mental Capacity Act and gained consent prior to any care being delivered. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

Where people required support with nutritional needs staff supported them with meal preparation. People were supported to maintain good health and were supported to access to healthcare professionals when necessary.

People and relatives felt the service was caring. Staff provided support in a respectful manner ensuring people's privacy and dignity was promoted. People were supported to be as independent as possible.

Support plans were personalised to include people's likes, dislikes and preferences. The provider had a system in place to ensure support plans were reviewed and updated where necessary.

The provider had a complaints process in place which was accessible to people and relatives.

Staff were extremely positive about the manager. They confirmed they felt supported and could raise concerns. People and relatives felt the management approach in the service was positive.

The provider worked with other stakeholders such as commissioners and social workers.

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.

Medicine administration records (MAR) contained gaps in signatures.

The provider had range of policies and procedures for staff to follow to keep people safe.

The provider had a robust recruitment process in place.

Is the service effective?

Good

The service was effective.

Staff received regular supervision and appraisal. Staff completed a mixture of on-line and face to face training.

People's nutritional needs were assessed and staff supported people to have a healthy diet.

People were supported to access healthcare when necessary.

Is the service caring?

Good

The service was caring.

People and relatives felt the staff were kind and caring.

People told us they felt supported by staff who treated them with respect and maintained their privacy and dignity.

The provider had information about advocacy services which was available to people.

Is the service responsive?

Good

The service was responsive.

People had support plans which were personalised. People were asked about their likes, dislikes and preferences.

Support plans were reviewed and updated whenever there was a change in need.

The provider had a policy and procedure in place to manage complaints. People and relatives told us they knew how to make a complaint.

Is the service well-led?

Requires Improvement

Systems were in place to monitor the quality and safety of the service , however these required further improvement to address recurrent medicine recording issues.

People and relatives felt the service was managed well. The office staff were responsive and helpful.

Staff felt the manager was approachable.

Statutory notifications were submitted when necessary.

Heritage Healthcare - Teesside

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.

The inspection activity took place on 6 and 26 June 2018. The first day of the inspection was unannounced.

We gave the service 48 hours' notice of the inspection visit because it is a domiciliary service and we needed to be sure that they would be in.'

The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed other information, we held about the service and the provider. This included statutory notifications we had received from the provider. Notifications are reports about changes, event or incidents the provider is legally obliged to send to CQC within required timescales. We contacted the local authority commissioners for the service, the local authority safeguarding team, the clinical commissioning group (CCG).

During our inspection we spoke with seven people who used the service and three relatives. We spoke with the manager, two care coordinators and four care workers.

We viewed a range of records about people's care and how the service was managed. These included the care records of six people, recruitment records of three staff, training records and records in relation to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Some people required support with their medicines. We found staff were trained in safe handling of medicines. Medicine administration records (MAR) were kept in people's houses for staff to refer to and sign. MAR were collected from people's properties monthly and stored securely in the office. We reviewed six people's MAR charts and found these contained gaps in recording. The manager provided evidence to demonstrate that staff had written the administration of medicines on the record of visit record.

We made a recommendation that the provider follows National Institute of Excellence (NICE) Managing medicines for adults receiving social care in the Community March 2017 in terms of best practice for record keeping.

We discussed the staffing rota with one of the coordinators who told us, "We always try to keep a team so people don't have a lot of different carers going in." Rotas give people information about which staff would be delivering their support. We saw that some calls were completed by individual carers and some with two carers where a person's needs were more complex.

The rota system printed the carers rota followed by the person's rota based upon who is the first carer at the call the following week. These rotas were then delivered by the manager and co-ordinator over the weekend to each particular area. This system was agreed with all staff members rather than posting them as some staff were not receiving their rotas in time for the following week. Staff felt at times this system was not working. We discussed this with the manager who advised rotas are done weekly and it is always the intention to get them to people in a timely manner. The manager said, "We make telephone calls when there are changes in carers so they [people] know if their regular carer is not able to visit."

People and their relatives we spoke with told us they received a copy of their rota in a timely manner. One person told us, "Yes, I get one every week". Another told us, "The girls bring it." One relative told us, "We get a copy weekly." A third told us, "I have had a phone call before if it's not [carer] coming, so I know."

People told us staff arrived on time and stayed for the correct amount of time. One person said, "If they [carer] are running late they always ring me." Another told us, "I have the same three or four, I have had them for 5 years now." One relative said, "We have a regular team of five, they are very good."

People and relatives told us they felt the service was safe. One person told us, "I would not change them for anyone. Everything is alright". Another told us, "I love my carers, I feel safe". A third said, "[Name] thinks of everything, I am well looked after". One relative told us, "[Name] can live independently and is kept safe with their support". Another said, "They are great [Name] is looked after".

The provider had a range of policies and procedures to keep people safe such as whistleblowing and health and safety policies. The manager told us they were updating the safeguarding policy following direction from the local authority so the policy related to children as well as adults. Staff had received safeguarding training and understood what constituted abuse and how to report their concerns. One staff member told

us, "We've had the training [safeguarding] so we know what to do." Another said, "I would report straight to the office." One care coordinator confirmed they had also received safeguarding training which also covered how to raise an alert with the local authority. This meant referrals could be made in a timely manner even when the manager was not in the service.

The manager kept a log of all safeguarding referrals and outcomes along with the corresponding notifications made to CQC. The manager told us, "If there is anything to learn from any incident then we would discuss at a meeting or in supervision." Staff confirmed information was shared at team meetings and in supervisions.

We checked the provider's recruitment process. Staff files contained application forms, checks in employment gaps, interview documents and identity checks. New employees had also received clearance from the Disclosure and Barring Service (DBS) that they were able to work with vulnerable adults and that they could do so without restriction.

The provider had introduced a new electronic care management system called PASS. The manager told us, "We hope to have everyone's records on the PASS system by the end of June". We reviewed three people's paper care records and three people's electronic care records. We found where risks had been identified control measures were in place for staff support and guidance. For example, 'I am at risk of dehydration', 'support workers are to leave jugs of water and juice for me after each visit.' We saw in paper records risks were reviewed on a regular basis or when there had been a change in the person's support needs. We were unable to evidence reviews of risk assessments on the PASS system due to early stage of systems implementation. The manager advised, "Reviews will be completed and records updated by the coordinators then staff will be able to see the changes straightaway."

Environmental risks were assessed to ensure safe working practices for staff, for example, to prevent slips, trips and falls and the location of gas and electric meter in case of emergencies. These were reviewed on a regular basis and were accessible for staff support and guidance. Staff had access to lone working risk assessments and guidance to support them.

At the time of the inspection the region was experiencing high temperatures. We saw the manager kept the coordinators up to date with weather alerts from the local authority. Coordinators sent a message to all staff to remind them to ensure people were offered and left with additional drinks. The manager asked the coordinators to send daily messages to staff until there is a respite in the weather. Coordinators made contact with the people who were supported to access the community to ensure they had access to sun screen.

Staff received training in infection control and had access to personal protective equipment (PPE) such as gloves and aprons. We found co-ordinators covered the compliance with infection control policies and procedures as part of their monitoring visits by checking that staff used PPE.

Good

Is the service effective?

Our findings

Staff told us sometimes they do not have a detailed written assessment and support plan to follow when carrying out a call to a new person. One staff member told us, "We don't always get enough information when going to new calls." Another told us, "I have contacted other staff when I have done a new call" (to provide information). A third told us, "I was just given a rota with a new person on." Staff told us they would always ring the office if they felt they could not meet the person's needs.

We spoke to the manager about the comments made by the staff. The manager acknowledged that sometimes they don't receive a lot of detail from commissioners especially if the call is an emergency. The contract they have with one local authority means they are obliged to pick up emergency packages. We found the provider had raised these issues with commissioning teams during provider forum meetings.

We were provided with records which demonstrated the information given to the provider when a package was commissioned as an emergency were not detailed. The manager told us, "We do try to give the staff as much information as we can, but it is difficult if we don't get a support plan. I have raised this with the [local authority]." They told us, "If it's an emergency call one of the care coordinators visit as soon as possible to carry out a full assessment."

People and relatives, we spoke with told us they had had an assessment visit from a coordinator before their support commenced as set out in the provider's policy. People told us staff had access to a file in their property which contained a support plan.

The records we viewed demonstrated people's needs and choices were assessed using current guidance and legislation. For example, moving and assisting guidance and infection control.

We saw where people required support with eating and drinking this was detailed in support plans. For example, [name] will choose a meal from the freezer, food is all pureed. Staff understood the importance of providing a healthy diet. One staff member told us, "There is always fresh food to make a meal. I always offer a choice of a hot drink." Staff told us they would report to the office if someone was not eating their meals or refusing their meals. One staff member told us, "I would tell the family as well, and record it."

We found the staff worked closely with other health care professionals, records showed contact with doctors, community nurses and dieticians. Specialist nurses were also involved in people's care and staff contacted them whenever there was a concern. For example, continence service. The manager told us, "Staff will ring community services such as district nurses and the GP. They [staff] can ring the office and the coordinators will ring. We've had staff ring 999 when there has been an emergency."

People and relatives told us they felt the staff were well trained and know who to provide support. One person told us, "They know what to do". Another person said, "I am used to them and they are used to me". One relative told us, "They are well schooled to look after [Name]". Another said, "Yes, they are trained".

We discussed the training needs of the service with the manager. The provider had signed up with the Teeswide safeguarding adults board to secure additional Mental Capacity Act and safeguarding training. Staff had completed a range of e-learning courses such as food hygiene and dementia awareness. Face to face training was delivered for courses such as first aid and moving and assisting. We saw that staff have a log on facility to complete their training at home or in the office. The manager used the online system to track staff's training. Messages were sent to staff by the system as a reminder when training was not completed within set timescales.

The manager advised that the provider was in dialogue with the online training provider to review the renewal dates of some subjects. The manager told us, "I have requested for safeguarding, MCA/DoLS, recording keeping and dementia to be completed annually." We found specialist training in respect of catheter care and stoma care was provided by the relevant specialist community nurse. A stoma is a small opening on the surface of the abdomen being surgically created to divert the flow of faeces and/or urine.

New staff completed the care certificate as part of their induction. The Care Certificate is a set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. Coordinators carried out a competency evaluation with new staff as part of their performance review. The evaluation was signed off when the staff member was deemed competent is areas such as, personal care, infection control, support plans and food hygiene.

Staff told us they felt supported by the coordinators and manager and that the training was appropriate to the needs of the people they were supporting. One staff member told us, "[External trainer] is brilliant, the training is really good." Another said, "I like the group training, hands on is better, we're on the ball with moving and handling [training]". A third told us, "They [external trainer] doesn't let you leave until you can do it [practical assessment]".

Supervision and appraisal records were available. Staff told us supervisions took place regularly. One staff member told us, "You don't have to wait for a supervision you can ring the office if you have a worry." Another said, "Supervisions are regular we have appraisals." A third told us, "Can't fault [manager] or [coordinator] they are good, we have team meetings."

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.

Staff were aware of the MCA and understood the principles of the Act. One coordinator told us, "We assess people's capacity as part of our assessment. Sometimes the plan from the social worker gives us information." We saw the new electronic system contained a section for capacity and consent. Staff gave us example of gaining consent before carrying out any personal care. One staff member told us, "I would always explain what I was going to do before I did anything and ask if that's ok." Another said, "I'd make sure they [people] were happy before doing anything." A third said, "If I was worried about anyone being forgetful or confused I would contact the office."

We found people's mental capacity was assessed as part of the initial assessment process. Best interest decision records were also in place. Where people had a Lasting Power of Attorney (LPA) in place, records had been scanned and uploaded into the electronic care management system. A LPA is a legal document that lets a person appoint one or more people to help make decisions or to make decisions on their behalf

when they are unable to. This meant staff had access to support and guidance if there were any decisions required about a person's health and well-being.

Good

Is the service caring?

Our findings

Every person and relative we spoke with gave positive comments about how caring the service was. One person told us, "I wouldn't change them for anyone". Another told us, "I love my carers, they are the best carers in the world". A third said, "I get excellent care, [staff member] is really wonderful, tremendous, she thinks of everything, I've no complaints. All the girls I have are kind and caring. They have been wonderful". One relative said, "I can't sing their praises enough." Another told us, "They think outside the box, we are reliant on them. I do trust them."

We spent time speaking with staff about their caring role. It was clear staff had developed positive relationships with the people they supported. Staff also spoke of the relationships they had with relatives as well. One staff member told us, "We always have a chat to the family as well, it's important." Another said, "I love to talk to them [people], find out their likes and dislikes, it's great to put a smile on their face." A third said, "If I have made [person] chuckle then that's worth doing. They class me as part of the family, it made me feel good."

People said they were treated with dignity and respect and they were involved in decisions about their care and support. We found staff received training in person centred care. We spoke with staff about how they promoted dignity and respect during their working day. One staff member told us, "You would always make sure you closed the curtains and the door if you were helping someone shower or bathe." Another said, "I always cover them [people] if I am helping them to get washed." A third said, "I treat people as I would want to be treated, it costs nothing to be kind. We are in their homes." Staff told us they always made sure the person was safe before they left and checked if there was anything else they needed, such as a drink or snack. All staff told us they gained consent from people before carrying out any support. Independence was promoted through encouraging people to do as much as they could for themselves. One staff member told us, "I would always let them try before giving them a hand."

Quality assurance survey results showed people and relatives felt staff showed respect and were kind. Comments included, "Although Mam is unable to act or make her own choices staff always ensure she is treated with total respect and kindness", "Our regular carers are friendly, respectful and I'm very happy with the service" And "I would like to thank all the carers for their hard work, care, dedication and understanding they are all earthbound angels – thank you".

Communication needs formed part of the person's support plan. For example, one person's support plan details the use of a white board to communicate. Advising, "I would like you to be understanding with me." Staff told us how they used different ways of communicating. For example, using facial expressions and gestures. If people needed spectacles or hearing aids to help with communication this was set out in their support plans. One staff member told us they used Makaton. Makaton is a language system which uses speech, signs and pictures to communicate with people who have communication needs.

Where people did not have family to support them the manger told us they would provide details of how to obtain an advocate. An advocate's role includes making sure correct procedures are followed and making

sure the person's voice is heard.

Good

Is the service responsive?

Our findings

The provider had recently purchased a new electronic care management system called PASS. The manager told us, "We are piloting the system with 12 staff members using the app on mobile phones to access the system, other staff are still using the paper based records." We found new people receiving support had their details and support plans on the electronic system. The manager advised the coordinators were working through people's records and transferring information on to the electronic system. The manager told us, "We hope to have everyone's records on PASS by the end of June, paper copies will still be held in people's houses." During our time in the office we observed coordinators carrying out this piece of work. Additional pieces of information were uploaded onto the system such as support plans from commissioners.

We reviewed both paper records and electronic records. We found paper based support plans were personalised, reviewed and updated whenever there was a change in need. For example – [Person] has specific feeding spoons, take kitchen roll with you and sit beside [person], use beaker with straw, likes a drink made for present and one for microwave later." We found whenever possible people had signed their support plans. We found people's likes, dislikes and preferences were used in planning support.

Electronic records also contained personalised information. Records provided information on how a person wished to be cared for. They covered all the needs that we saw people were assessed as having including area their; communication, relationships, emotional, social and spiritual needs. For example, one person's plans advised, "I can make my own decisions around my personal care and would like to carry on doing this, I would like carers to keep an eye on my skin and report any problems to my mum." Another detailed, "Make me a cup of tea I don't have sugar just milk, I have it in a larger than normal cup." We saw people had signed the electronic tablet used by the coordinator which uploaded their signature on to their support plan.

Due to the newness of the system the electronic support plans had not been reviewed. The coordinator showed us how support plans would be reviewed on the system and how changes would be made. The changes were immediate and staff would be notified via the message system.

People told us they were issued with support plans for their information. Along with an information pack which gave important advice and details of the service.

Where social time is part of the person's support plan staff provide opportunities to access the community. One relative told us, "They are great, [Person] gets out and about, it's important to him."

People and relatives knew how to raise a complaint or concern. Everyone we spoke with had positive comments about the service and had no complaints. One person told us, "I know how to [make a complaint] but haven't needed to." One relative said, "I have never made a complaint, but have contacted the office and they were fine." We found there was a clear policy in place for managing complaints. We saw that complaints received had been fully investigated, an outcome shared with the complainant. We saw where possible learning from concerns and complaints had been cascaded to staff through staff meeting and supervisions.

No one was receiving end of life care at the time of the inspection. The manager told us, "Staff know how to provide end of life care, we have worked closely with the district nurses and social workers."

Requires Improvement

Is the service well-led?

Our findings

The providers quality assurance system required further improvement in relation to poor record keeping pertaining to the management of medicines. Regular audits of the MARs were completed as part of the quality assurance process. We found the audits from 2017 and 2018 identified an ongoing issue with gaps on MAR charts and poor record keeping in respect of using a code to indicate when a medicine had not been given/taken. We saw where they had been gaps or anomalies these were recorded with a record of what action had been taken. For example, discussion with staff member. However, despite action being taken the issue with poor record keeping in relation to medicine management had continued.

We discussed these ongoing concerns with the manager who agreed staff continued to leave gaps in recording and not complete records correctly. The manager told us, "I intend to get staff in for a meeting to explain the importance of recording and to organise further training."

We saw coordinators observed staff on a regular basis to ensure their competency in supporting people with their medicines. People told us staff supported them safely with medicines.

The service did not have a registered manager. The manager had applied to CQC to become the registered manager but their application had been rejected due to an administrative issue. We discussed the application and the manager advised they were in contact with CQC registrations team.

'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.'

The provider had implemented a new quality assurance process in November 2017. The process used the key lines of enquiry (KLOE) used by CQC inspectors when planning and inspecting services. KLOEs form part of the methodology CQC use to determine if services are safe, effective, caring, responsible and well led. We found audits covered areas such as staff recruitment, support plans and records of visits. Where shortfalls were identified these were recorded with actions to be taken. Either the manager or coordinator signed off completed actions.

As there is no registered manager in post, we contacted the director of Heritage Healthcare Teesside to ask about provider oversight. They emailed advising, "More robust auditing was implemented which included auditing the audits that have been conducted which is conducted by Senior Management. Key Performance Indicators Reports are submitted monthly by each manager to Head Office and these are discussed with managers. These were updated recently to include much more detailed information that assist the management team as a whole. These also form part of the quarterly management team meetings at Head Office in Darlington". We evidenced the provider's audit reports which demonstrated actions set by senior management.

People and relatives felt the manager was approachable. One person told us, "I have contacted them, they're ok." Another said, "You can ring, they are approachable in that way". People felt staff in the office were also helpful.

Staff felt the manager was open and willing to listen. One staff member told us, "[Manager] is good if you need to talk". Another said, "Can't fault her, she will help you." A third said, "We get support from the office, I would not work for anyone else." Staff felt there was a team approach to Heritage Healthcare Teesside. One staff member told us, "We are fantastic as a team. We support each other."

One local authority contract and commissioning officer told us, "The manager is approachable." The contract and commissioning team are supporting the manager with the transition of the service as they now cover a larger geographical area.

The manager had a clear vision for the service moving forward. This included the full implementation of the PASS system as well as supporting staff with the changes this entails. Plans to review and amend the renewal dates of staff training were in place. Contact with other stakeholders had been made to develop the service in terms of safeguarding and MCA training. We found the manager had supported the coordinators in their role by empowering them in terms of implementing new systems and processes.

Regular meetings were held with staff. These were recorded and made available for those who could not attend.

Quality surveys were carried out so people, relatives, other stakeholders and staff could give their views and opinions. We saw the provider acknowledged any concerns raised and addressed the concerns as part of their development of the service.

We found the provider was meeting their requirements in line with CQC (Registration) Regulations 2009. Statutory notifications had been submitted in a timely manner.