Sanctuary Home Care Limited

Sanctuary Home Care Ltd - Exning

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on the 12 and 14 July 2016 and the service was given 48 hours' notice in line with our methodology for domiciliary care agencies. We gave notice in order for the care manager to contact people using the service and ask their consent for us to visit them. We visited five people using the service. We had previously inspected this service on the 24 June 2014 using our old methodology. The service was non-compliant with supporting workers and we made a compliance action. The provider sent us an action plan telling us how they had addressed this.

The service is split into two parts with Sanctuary housing who provide accommodation for people who may or may not have an assessed care needs. People pay a weekly charge to have staff available twenty four hours a day and a call bell system to enable people to contact staff in an emergency. Housing issues are dealt with through an on- site housing manager. In addition there is a registered manager who oversees the care hours people might have which are either contracted hours of support or non- contact time which is support provided in an emergency. On site there are 34 flats and a number of communal areas such as a communal laundry, lounge and dining area for the benefit of its residents. The housing manager was responsible for overseeing the catering arrangements where people could pay for a cooked meal on site if they wished. This report relates to the care provider.

There was a registered manager for the regulated activity of personal care. 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.

People's experiences of the service varied with a number of people experiencing difficulties in a number of different areas: including failures in the heating and hot water, issues around the availability of a chef during the week and weekend and people not always given sufficient notice of when a hot meal was not going to be available so people could make alternative arrangements. There were concerns about activity level and general maintenance issues. All these issues related to people's housing contract and not their care contract so we could not consider these as part of our inspection. However these issues had the potential to negatively impact on people's health and a greater cohesion between housing and care matters would improve people's overall.

People spoken with were happy with the care they were provided with and benefitted from a regular staff team who were familiar with their needs. Staff were based on site so could be flexible in their approach. People had set visit times but staff demonstrated that they were flexible and responded to changing needs. Some people spoken with were concerned that at night there was only one member of staff and felt this to be inadequate. We were given examples of why people felt this was inadequate and noted that a number of people had high dependency levels. Two people required two staff to assist with manual handling. People had appropriate equipment in place to help maintain their skin integrity but staff were unable to change their position at night.

People were supported to remain healthy but we could not always see clear monitoring of people's needs. We felt this was a records issue as some records were ambiguous and care plans were not always updated when people's needs changed.

Staff were trained for their role and felt well supported. Staff had completed all the training essential to their role but not all staff were sufficiently familiar or confident with the needs of people with long term health conditions such as diabetes. The manager said they would address this.

Staff recruitment processes were sufficiently robust which meant that only staff suitable for employment were recruited and there were systems in place to monitor staff such as spot checks on their performance.

Staff provided timely, appropriate care in line with people's wishes and only after consent had been sought.

People received their medicines as required and staff were trained to undertake this task. There were audits in place to help identify any errors and to ensure people had their medicines in stock for when they required them.

The service engaged with people about their care and how they would like it provided. There were systems in place to judge and measure the quality of care provided. This meant improvement could be identified and actioned as necessary. Improvements were required in relation to staff competencies and skills and to ensure their knowledge was sufficient to care for people they were supporting. Care plans also needed to reflect the care staff were providing.

We found a breach of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 in multiple regulations. You can see what action we told the provider to take at the back of the full version of this report.

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 meet people's needs and this was kept under review.

The service had robust staff selection and recruitment procedures in place.

People received their medicines as prescribed by staff who were trained to administer it.

Risks to people's safety were mitigated as far as reasonably possible by assessing the risk and taking clear steps to reduce it.

Is the service effective?

Requires Improvement

The service was effective.

Staff had sufficient skills and were supported in their role through induction, training and supervision.

Staff provided care and support to people according to their needs and wishes and with valid consent.

People were supported to eat and drink enough for their needs.

People were supported with their health care needs

Is the service caring?

Good

The service was caring

Staff were familiar with people's needs and promoted people's autonomy and independence.
People were involved and consulted about their care needs and how they wished it to be provided.

Staff were respectful and caring.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

Staff knew people well and responded to their changing needs. However people's care records did not always reflect people's needs accurately or take into account any risk or unmet need.

There was an established complaints procedure and feedback from people was acted upon to improve the service.

Is the service well-led?

Good

The service was well led.

The manager provided clear leadership and direction.

There were systems in place to obtain feedback from people about the service and to make changes as required.

There were robust quality assurance systems which assessed and measured the effectiveness of the service being delivered.

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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 took place on the 12 and 14 July 2016 and was announced. We gave the manager 48 hours' notice of our proposed visit to give the manager the opportunity to ask peoples consent for us to visit them as part of this inspection.

The inspection was undertaken by one inspector over two days. As part of this inspection we spoke with six people using the service, five staff and two relatives. We also looked at people's records to see how their care was being provided and other records relating to staffing and the management of the business.

Good

Is the service safe?

Our findings

There were enough staff to meet people's assessed needs. Some people had a concern about the night time care calls which finished about 1.30 am according to need. Some people said that if an emergency arouse staff would not be able to respond quickly if they were attending to other people as there was only one night staff on duty. There was no evidence to support this. We were given a recent example in which night staff had to deal with an incident late at night. They had contacted the out of hours on call system and said staff were there within 15 minutes. If for whatever reason a call bell was not answered rapidly it would be diverted to a call centre who would ascertain what the problem was, call for emergency back up and try to establish why staff on site had been unable to respond quickly. The service used to have sleep in staff to support waking staff but said they were rarely called upon so there was no rational to maintain this. Two people required support from two staff to be moved safely. This meant at night, staff were unable to turn them. However their skin was intact and they had the right equipment in place so we did not identify any negative outcomes for these individuals but there was a potential that their needs could change in the future.

People using the service said they were well supported and people's needs were met within the allocated time. The longest call time was 45 minutes, the shortest 15 minutes and staff had no travel time and gaps between visits which gave them the flexibility they required. Staff said they were able to fit in additional calls or split the calls according to people's needs. Staff gave an example of a person who was not eating. We were told they went from no calls to three calls a day as their needs changed. Staff spoken with said there were enough staff and they did not feel pushed for time. Staff said the manager was aware of people's needs and adjusted staffing hours accordingly. Staff said because they knew people well they could anticipate people's needs and provide support accordingly.

There were enough staff employed to deliver the care. Staff recruitment was on-going and there was a twenty hour vacant post. The manager told us they had some bank staff on zero contract hours who could pick up additional shifts so they were not reliant on agency staff and had not used agency staff since coming into post in 2013. We looked at staff rotas, timesheets and allocation sheets which showed that all calls were adequately covered.

People were safeguarded from abuse as far as reasonably possible and people told us they felt safe. . The manager had a good understanding of safeguarding and how to report and respond to any allegation of abuse. There had not been any reported safeguarding in recent months and we saw that previous safeguarding concerns had been well managed and carefully documented. The organisation had developed and recently forwarded standard procedural manuals to support manager's to deal with reported safeguarding incidents in a uniformed way. The manager had been absent for a while helping to cover another scheme and in her absence senior staff spoken with were less knowledgably about how to raise a safeguarding concern and when it was appropriate to do so. The manager provided us with evidence of staff training in protecting adults from abuse and also showed us that they discussed this with staff as part of their one to one supervisions and annual appraisals. Therefore we believe this matter to now be addressed fully.

We asked the manager about any recent safeguarding concerns. The last one recorded was viewed and we saw that appropriate steps had been taken to safeguard the person. It related to the person no longer being able to take their medication safely thus putting themselves at risk. The service had communicated with the person, their family and other health care professionals to ensure decisions were taken in the person's best interest and lessons learnt.

Staff recruitment was robust and we saw evidence of how staff selection was made. Records confirmed that staff were only employed after stringent checks were made to ensure they were suitable for employment. These checks included: a criminal records checks, employment history, character and job references, and proof of identification, address and eligibility to work.

Some people raised concern with us about the thoroughness of the staff's recruitment process and the amount of experience staff had. Some people using the service could contribute to the interview process which might help ensure staff employed were able to meet the expectations of people they were supporting.

People received their medicines in a safe way. People told us about the support they received with their medication. One relative told us they collect medicines and staff administer it. One person told us, "I do not need help with my medicines, but take paracetamol for my pain, carers help me with that."

Staff who administered medication had received training which was refreshed annually. Medication competencies were carried out to ensure staff had understood their training and were able to give medicines safely. Spot checks were completed for staff which involved observing their practices to ensure they were administering medicines safely. Spot checks were also completed on medication records and stocks of medicines to ensure medicines had been signed for and tallied with what staff had recorded should be in stock. This helped to evidence that people received their prescribed medicines and also helped to identify errors. The manager had completed enhanced training around managing people's medication and told us that team leaders were booked on the same course in August 2016.

A number of medication recording errors had been identified by the provider. Staff had forgotten to sign when administering medication. These were logged on an incident record and kept in people's record. The manager said this was discussed with staff as part of their supervision. There were procedures in place for dealing with medication errors to minimise the risks to people using the service. The team leaders completed weekly spot checks on all medicines and medicine records to ensure their accuracy.

We also noted discrepancies in their medication and were not clear if pain relieving medicines prescribed were for regular or occasional use as records had not been updated. This was raised with the manager so they could immediately check this. We noted that despite the person being in pain and taking regular pain relief there was no tool in place to assess the person's pain threshold and it was not clear if the person could actually tell staff how much pain they were in.

People's care plans identified people's medical needs and any medication they were taking. This included any specific instructions. People were promoted to maintain their independence and several managed their own medicine. Staff would report any concerns if they felt they were not managing their medicines safely. Risk assessments were in place for people taking their own medications.

Risks to people's safety were documented and actions were in place to reduce risk as far as reasonably possible. Flats were designed around the needs of people using them and people paid for a call alarm system. As part of their housing tenancy a risk assessment was completed in relation to any environmental

hazards and this was kept under review. In addition care assessments identified any hazards to staff or people when receiving care or in relation to their health care needs. If there was an identified risk, a plan of care was put in place. For example risk from dehydration or malnutrition would be recorded and monitored by staff. Food and fluid charts would be kept by staff to demonstrate what people were drinking/eating and how often staff were encouraging them to do so. People's care records also included manual handling assessments; assessments on how to promote good skin care and a recording system for staff to record and report any injury or bruising.

The service learnt from mistakes to ensure people's continued safety. For example the manager told us about the risk assessments they completed when planning an activity and also actions following an adverse event. This was clearly documented. The manager told us they meet as a group of managers across the organisation and discussed any risks/safeguarding concerns

Requires Improvement

Is the service effective?

Our findings

We spoke with people using the service. One said, "The staff are adequately trained, they know what they are doing." Another said, "New staff are supervised." However one person was concerned that some staff lacked experience and did not have sufficient knowledge of specific conditions such as diabetes. They told us staff had asked their advice. Another person said, "New staff don't know how to do things." We saw a lack of specific information in people's care plan about specific health care conditions. The manager told us guidelines were in the staff's rest room. We suggested specific guidance should be in people's records. From training records we saw that some staff had received training in managing long term conditions but this was not sufficiently robust and some staff had either not had training or had not had updates in a long time. Examples included diabetic care and end of life care. The manager had an in-depth knowledge about diabetic care and agreed they could provide an information session for staff and said they could do this quickly. There were people who managed their own insulin and others supported by the District Nurses but it was important for staff to know how to monitor people's health and well- being should they become unwell.
Staff were familiar with the requirements of their role and sufficiently trained to meet the needs of people using the service. We saw individual staff records and the training and supervision matrix. This showed us that most of the essential training was up to date or scheduled. We saw for the month of June 2016 staff had completed training in food safety, catheter care and medication competencies had been done. Each month there was a breakdown of the training that had been completed which showed us staff had regular opportunity for training. The manager gave us some examples of recent staff training such as catheter care and told us they had access to a learning academy which covered a lot of essential training for staff but could also access additional training when a need was identified.

The staff's probationary period was thorough. New staff were shadowed on a variety of shifts for two weeks if required. All established staff were responsible for shadowing staff and initial shadow shifts were recorded to show what the staff member had been shown and what the staff member had been observed as doing with room for feedback or any issues identified. New staff were also completing the Care Certificate. This is a nationally recognised foundation course for care staff. Senior staff had undergone training to enable them to support care staff with their induction booklet and assess their competencies.

We spoke with staff recently employed at the service. They confirmed that they had completed an induction and a series of shifts in which they were shadowed by more experienced staff.

Staff told us in addition to one to one support, they attended regular staff meetings and had spot checks on their performance, regular training and annual appraisals. Staff told us the manager and senior members of staff were approachable so staff felt able to ask for support as needed. The service had incentives for staff to help support and develop them and recognise their achievements through recognition.

Consent to care and treatment was sought before being provided and people's wishes were recorded. Everyone using the service had been assessed as having capacity and there were no restrictions in place for people. We spoke with staff about their understanding of the Mental Capacity Act 2005 and supporting

people around decision making. Staff understood the legal requirements of the Act and how to act in the person's best interest. We saw that staff had received training in this area and their knowledge had been tested to ensure they understood the training and could act upon it to provide appropriate care to people.

We saw that people's care plans contained consent forms signed by the person receiving care, as well as their representative, for receiving care. We observed staff communicating effectively with people and asking their permission and explaining what they were going to do.

Where people had Do Not Attempt Resuscitation (DNAR) Forms in place these were in the file. However staff were not always aware of these and might not be able to access them in an emergency. We recommend that the manager has a system where this information is readily available.

People's capacity had been assessed prior to admission and where capacity was in doubt the service worked with families and other health care professionals to ensure decisions were made in people's best interest. The manager understood this and was able to give us clear examples.

People were supported to eat and drink. We saw examples of where people needed support to eat and drink and with food preparation. This was given by staff who did so at a time of the persons choosing. Staff carried out additional visits to prompt people with food and drink and there were some care plans and records to support this. However we did not see much analysis of the information collated to form a judgement as to whether people were eating or drinking enough or what other actions staff should take. Referrals were being made primarily to the GP but also other health care professionals and monitoring visits from the district nurses.
People's health care needs were documented and mostly met by care staff. People were responsible for making their own health care arrangements but most people had family support. Staff were aware of people's needs and monitored them on a daily basis. Information was passed from one shift to another through handover and the use of a communication book. Some information pertinent to an individual's care was recorded in the communication book and not in their individual care notes. We would recommend that anything specific to an individual's care and support should be recorded in their record to enable the service to comply with the Data Protection Act.

Staff spoken with said they knew people well and closely monitored people's health. They said they had good relationships with other health care professionals and could access them as needed. Most people were registered with their own GP and made their on arrangements for chiropody, opticians etc.

Good

Is the service caring?

Our findings

People using the service were happy with their care and support. One person told us, "I can have a laugh with the carers; they treat me with dignity and respect." Another told us that they got on with all the staff and most were longstanding members of staff who knew their needs well.
We spoke with staff and observed their practice. Staff were respectful and demonstrated a warmth and empathy towards people they were supporting. One person expressed concern about the attitude of a member of staff and we informed the manager about this. We found that some people expected more from the staff than agreed as part of their care plan. This resulted in some dissatisfaction. People were expected to be able to live independently with varying degrees of support. Staff were expected to encourage and enable people's independence and help them retain control over their lives. The service did well to manage the right balance of support as a number of people had high care needs and required frequent visits to ensure their safety and well- being. One person told us they had to keep their door locked as a person would sometimes come into their flat and did not always wish to move. This was currently being managed by appropriate staff intervention and the person whose flat it was good humoured about it. Staff told us how they respected people's self-determination and how they tailored the support to each individual.

Staff described people in a respectful, understanding way and we saw staff asking people for their permission before providing any support and gaining the persons consent before proceeding. We observed people knocking on the doors before entering people's rooms and providing support to people in the communal areas.

We spoke with relatives. One told us about the care of their mother and said that staff were friendly and chatty and respected professional boundaries. They told us there was good consultation and we saw evidence of this in daily notes which picked up any health care issues and showed how staff had responded and acted upon these. The family confirmed they were invited to care reviews and they were asked to complete surveys asking them about the care and support their relative received. They told us communication was good and there were relative-resident meetings. People confirmed that they were consulted about their care needs and there were meetings about the service provided.

Requires Improvement

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. However records were not up to date and did not always show what actions staff had taken to meet people's needs or mitigate risks.

We spoke with people using the service and most expressed their satisfaction with the support they received. One person told us the support they needed was variable and had reduced over the time they had been there. This was due to their increasing independence and stabilising physical health. The service had responded to their needs providing increased support which was gradually reduced in line with their needs. Another person's needs had increased and staff support had been adjusted several times to accommodate this. People told us that if they needed to change the time of their support or if they needed additional support due to ill health then this was provided.

We looked at the care plan of one person whose needs had changed recently due to a change in their circumstances. Their care plan was not up to date. It was last updated in September 2015. The manager confirmed their care plan required updating. We would expect care plans to be reviewed as and when people's needs changed and a delay could result in the person not getting the care they needed or there being no plan in place to address their needs. We noted that the person had been in hospital earlier that year and this had not resulted in their care plan being updated.
As part of this inspection we observed the person and saw they were content and staff were regularly visiting them to ensure they were comfortable and were eating and drinking enough for their needs. Their family had no immediate concerns and reported that the person had lost weight but felt staff supported them to eat and drink. They told us the persons skin was prone to breaking down but said the service were proactive in reporting any skin changes to the district nurses so they got the treatment they needed. They told us their skin was currently intact. However the person was not being turned throughout the night because there was only one member of staff on duty. Family told us, "They have had the occasional sore but staff keep on top of it." We were unable to see a risk assessment around maintaining their skin integrity although they did have equipment, barrier. creams and a special mattress to help alleviate further skin damage. Their manual handling assessment was not up to date.

We looked at another person's records for someone with really complex needs and they had not had their care plan reviewed for well over a year despite them having a degenerate disease. A fourth person's care plan was also not in date. Their manual handling plan said they could mobilise when in fact they were no longer able to do this. Their record also showed no real evaluation of the risks associated with not drinking enough and the risk of infection. We also noted that the standard of recording varied. The care plan of the person with a degenerate condition was in considerable depth although the information was out of date. Other care plans gave ambiguous information such as assist with eating, assist with washing and dressing which did not tell staff what the person could do for themselves and might result in differential care.

Falls were reviewed but not always linked to the risk assessment. For example someone whose nutrition was compromised was falling and this was recorded but their falls history did not result in their falls risk assessment being updated. We could see staff were taking actions but information was inconsistently

recorded.

Risks to the person were mitigated because staff were familiar with their needs and there was regular family involvement. However records were not in sufficient detail. We noted some documents were not dated, there was no night care plan and the person was not getting support throughout the night and were unable to use their call bell. The manager said staff would check on this person throughout the night but this was not evidenced through their daily notes. Their records showed us that the person was not always eating and drinking enough as there was no clear guidance for staff about how much the person should drink and what actions staff should take if they did not reach their daily intake. The repositioning charts showed gaps and did not tell us what position the person had been put in previously to alleviate pressure on their skin.

We have identified a breach of regulation 17: Good Governance in relation to the poor recording of peoples changing needs in their care plans.

We case tracked another person who had high needs and an increased number of calls to accommodate this included night calls to ensure the persons safety as they sometimes became disorientated to time and place. Their relatives were happy with the care and support they received and felt staff were responsive to their needs. They told us staff were aware of their needs and responded accordingly and at a time which suited the person.

We noted another area of concern was the assessments carried out were not always shared in a timely way. A person requiring a service would complete an application and the housing manager would complete an assessment based on housing need. This assessment would include a risk assessment. Social care assessments would be completed for people who had support with funding. However self -funders could move in without an initial care assessment. The manager did not always have sufficient information about a person prior to moving in which did not always help to ensure they could put in the required amount of support. There was not a joint housing/care assessment. This did present a number of problems. For example if people paid for their own care and their needs increased they would have to pay for additional support which they might not always wish to do resulting in unmet care needs. This in turn would result in notice being served.

People social needs were not fully met as it was the responsibility of the person, friends and family to support the older person. The housing manager had a small budget for activities but most people expressed frustration that this was insufficient. However the service was registered for personal care which does not include activities. There were a number of things organised for people using the service and things organised by people using the service. Examples included a gardening club, church services and a visiting pat dog. Parties were held at Christmas time.

The service had a complaints procedure and people spoken with were aware of it. One person raised concerns with us about the practices of one of the care staff. This had been dealt with in a satisfactory way and demonstrated the service was responsive to feedback. Another person also told us concerns they had about a carer but again said there concerns had been responded to. They also had concerns about their housing situation and the maintenance. This element is not regulated by CQC under this registration. It had not been resolved and was passed on to the manager who addressed this with the housing manager. One person told us they had tenants meetings but these were not as frequent as they once were. They told us that since there was a change in care providers some years ago there were lots of changes around what the care staff could support them with.

We saw a number of compliments about the service provided to people

Good

Is the service well-led?

Our findings

The provider send out annually questionnaires to people or their representatives asking for their feedback of the service provided to them. The results of this were compiled and then the manager would be sent the results and asked to produce an action plan if there were any concerns raised. This year's survey had been completed but the results had not been made available as yet to the manager. People using the service told us that surveys were sent out and they had been asked for their feedback. In addition tenant's meetings were held, the last being a joint one between care and housing and minutes were available. A few people said this did not result in positive changes. Examples given related to housing not care issues. The frequency of the meetings had also suffered as the service was without a housing manager for some of the year and the care manager was covering more than one scheme. However this had recently improved.

Feedback about the manager was very positive with everyone stating she was approachable and kind and helpful. One staff member told us, "I am so happy here it's terrific." We observed her interactions with people and staff and they were warm and professional. One member of staff said, "We go above and beyond and pull together. We are a cohesive team."

We found the manager very open and honest and was clear that some things were not up to date but this was because they had been required to help manage a second service which had put a strain on the first. However there were senior staff who managed Exning court in their absence so at no point was the quality of care provided compromised

There were audits in place to measure the quality and effectiveness of the service provided to people. This included spot checks on staff and feedback obtained from people about how the staff were supporting them. Medication spot checks were done weekly. New frameworks had been introduced for a number of key areas of practice such as managing safeguarding concerns, medication and recruitment. The manager was undertaking regular supervision, staff meetings and annual appraisal of staff performance to ensure staff had sufficient competencies for key areas of practice. All of these practices were driving improvement. Some training was out of date but this had been identified by the manager and was being addressed and the manager had agreed to provide support to staff around meeting people's specialist needs.

The manager was required to submit data to their managers and reported on key aspects of the service delivery such as staff sickness, accidents, incidents and anything impacting on people's health needs and, or safety. We saw action plans were developed in response to any identified issues such as falls which were monitored and responded to by the service. The way audits were being completed had changed and were more in depth and more in line with CQC key lines of enquiry. This showed us that the provider had oversight and was aware of what was happening within the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not fully assessing, monitoring or mitigating risks relating to the health, welfare and safety of people using the service. They were failing to keep an accurate, up to date contemporaneous record of the care given.