Sevacare (UK) Limited

# Synergy Homecare - St Helens

## Inspection report

1st Floor, 14 Hardshaw Street
St Helens
Merseyside
WA10 1RE

Date of inspection visit:
27 July 2018

Date of publication:
14 September 2018

## 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 inspection took place on 27 July 2018 and was announced

At the time of our inspection the service was providing packages of care to 29 people and employed 14 staff.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community [and specialist housing]. It provides a service to older adults and younger disabled adults.

This was the registered providers first inspection at this location.

Synergy Homecare St Helens, is registered to provide personal care to people in their own homes.

There was a registered manager in post.

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.

Staff were able to describe the process they would follow to report actual or potential abuse, this mostly consisted of reporting the abuse to the line manager. The service had a safeguarding policy in place, which we viewed and staff we spoke with told us they were aware of the policy. Safeguarding training took place as part of the induction for new staff and was refreshed every year.

Staff recruitment records showed that staff were safely recruited after a series of checks were undertaken on their character and work history.

Risk assessments were in place and were reviewed regularly or when people's needs changed. Risk assessments contained details of how to support the person appropriately, while mitigating risk. They were instructive and clear.

Staff were supplied with personal protective equipment (PPE). This included gloves, aprons and hand sanitizer. Staff we spoke with told us they were always able to ask for more PPE when needed. Staff had completed infection control and prevention training, and understood the importance of reporting outbreaks of flu and vomiting to the manager, so they could cover their work so as not to spread the infection.

People were supported with their medication in accordance with their assessed needs and in line with recent guidance.

The registered manager and the staff understood the principles of the Mental Capacity Act 2005 and associated legislation.

People were supported as part of their assessed care needs with eating and drinking and staff were aware of people's preferences.

Staff undertook training in accordance with the providers training policy. Staff told us they enjoyed the training. Staff spoken with confirmed they had regular supervision and appraisal.

Additional role specific training took place to help people manage their support needs. This training was overseen by a registered nurse who assessed staff competency once they had attended the training.

Staff supported people to access other healthcare professionals such as GP's and District Nurses if they felt unwell.

People told us that the carers who visited were all very caring and would always ask them how they are feeling and ask them what they would like help with.

People we spoke with were complimentary about the caring nature of the staff and we received positive comments about the registered provider in general.

People told us that they were always kept informed and involved in their care.

We did not observe care being delivered, however, people told us staff were kind and caring in their approach.

Care plans contained detailed information about people, what their preferences were and how they liked their care to be conducted. Information in care plans was regularly reviewed and updated in line with people's needs. This meant that the registered provider was responsive to people's needs and preferences.

Complaints were investigated in line with the complaints procedure and responded to appropriately.

Audits took place which checked service provision and action plans were implemented to improve practice.

Feedback was gathered from people using the service and people told us they felt that the registered manager had responded to their comments. Feedback was conducted every few months over the telephone, and annual audits were due to be completed.

Team meetings took place, and we viewed minutes of these.

## 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.

People received their medications on time.

Staff recruitment was robust and checks were undertaken on staff before they started working for the service.

Risks to people were assessed, and there was information on how to manage these risks.

People told us they felt safe receiving care from Synergy Homecare.

### Is the service effective?

Good

The service was effective.

Information around the Mental Capacity Act and associated principles was clearly documented.

Staff had the correct skills and knowledge and undertook training relevant to their roles.

People were supported with their meal preparation in line with their assessed needs.

### Is the service caring?

Good

The service was caring.

People told us staff were kind, caring and treated them with dignity and respect.

People's preferences were reflected throughout care plans. This helped staff get to know people and provide care based on their needs and preferences.

Care plans promoted people's choice and independence.

### Is the service responsive?

Good

The service was responsive.

There was a process in place for recording, acknowledging and responding to complaints. People we spoke with told us they knew how to complain.

People received care which was planned and personalised in accordance to their preferences. Staff demonstrated that they knew people well.

Staff were trained to support people who were on an end of life pathway to remain comfortable in their home with additional support from other medical professionals.

## Is the service well-led?

Good

The service was well-led.

A range of quality assurance audits were completed regularly to monitor and improve service delivery.

Staff we spoke with were positive in respect of the overall management of the agency and the support provided by the management team.

The registered provider had notified the Care Quality Commission (CQC) of events and incidents that occurred at the service.

# Synergy Homecare - St Helens

**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.

This inspection took place on 27 July 2018 and was announced.

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

We visited the office location on 27 July 2018 to see the manager and office staff; and to review care records and policies and procedures. We also made phone calls to people who used the service to get their views on the care provided.

The inspection team consisted of an adult social care inspector and an expert by experience with experience of using domiciliary care services.

Before our inspection visit, we reviewed the information we held about Synergy Homecare. This included looking at the notifications we had received from the provider about any incidents that may have impacted on the health, safety and welfare of people who used the service. We also looked at the Provider Information Return (PIR) we received from the provider prior to our inspection. This form asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We used our planning tool to help us plan the inspection and decide how we were going to conduct the inspection.

We spoke to nine people who used the service and their relatives. We spoke with five staff, including the

registered manager and provider. We looked at the care plans belonging to three people and other related records. We checked the recruitment files for three staff. We also looked at other documentation associated with the running of the service.

Good

# Is the service safe?

## Our findings

People we spoke with told us they felt safe with the care being provided by Synergy. One relative said, "They [care staff] are reliable which gives my [relative] piece of mind." Other people described the staff as "Friendly", "Chatty" and "Outstanding". No one we spoke with raised any concerns regarding their safety or that of their relatives.

We looked at how staff rotas were managed by the service. We saw that people's call times were adequately spaced, with enough travel time in between calls for staff to get to and from people's homes on time. Staff we spoke with told us that they were happy with their rotas and they mostly visited the same people. This meant that staff were able to develop relationships with people, and the registered provider offered consistency for people receiving care.

We discussed the procedure for Electronic Call Monitoring (ECM) with the registered manager. ECM is a technology where carers 'sign in' to their calls either using a smartphone or the person's home telephone. Due to the service only having 29 people and not contracted to complete larger packages of care, this was not something that was in place. However, the area manager and registered manager did say this would be considered as the area grows. The service ensures staff arrive at their calls either by making random out of hours calls to people's homes, or depending on family members or life line to let them know.

We saw that there had been two missed visits in the last 12 months which had been investigated as a quality concern rather than a safeguarding concern due to the fact the people involved never came to any harm.

Staff were able to explain the course of action that they would take if they felt someone was being harmed or abused. Staff we spoke with said they would 'whistle blow' to external organisations such as CQC if they felt they needed to. Staff had received training in safeguarding and their responses were in line with procedures set out in the service's safeguarding policies. This stated that staff should report all potential abuse to the appropriate authorities. Information regarding safeguarding for people who used the service and relatives was readily available within the service user guide and the office. People we spoke with confirmed they knew how to raise concerns should they have any.

Accidents and incidents were accurately recorded and were reviewed by the registered manager in order to identify any patterns and triggers. This meant that the registered manager was overseeing if trends were being established and how to safely manage risks. There had not been many accidents in the last twelve months.

We checked to see how the administration of medication was being managed at the service. People's medications were stored in their own homes. We saw that reasons for people self-medicating or not, were clearly documented. People prescribed PRN (medication when required) had a detailed protocol in place which explained when the PRN was needed and why. Staff recorded their signatures in Medication Administration Records (MARs) when they had helped someone take their medication. There was also a list of all medications the person was taking within their care plans. This meant that staff knew what medication

each person took and what it was used for.

The registered manager completed risk assessments to assess and monitor people's health and safety. There were risk assessments and management plans in place for falls, manual handling, pressure care and nutrition. Each care plan contained risk assessments which showed the relevant risks, control measures and how to mitigate the associated risks.

Risk assessments were highly detailed and contained a lot of information regarding people's care needs. For example, there was a moving and handling assessment in place for one person. This stated specifically what transfers were needed to be made, and how many carers should assist with this. The assessment also stated that the person had a catheter in situ. Additionally, the risk assessments stated that the person could communicate verbally with people, and could instruct the carers.

Another person was at risk of dysphagia. We saw that there was detailed risk assessment in place which instructed staff on what processes to follow to ensure that this risk was minimised. For example, to ensure that the persons drinks were thickened to the correct consistency, and to always leave them wearing their lifeline pendent.

Each care file contained an environmental risk assessment. This had been completed at each person's home during the initial assessment process to highlight any potential hazardous working conditions for staff such as pets or stairs. Action had been taken to minimise risk to both staff and the person they supported.

We reviewed three personnel files of staff who worked at the service and saw there were safe recruitment processes in place including; photo identification, employment history, two references and Disclosure and Barring Service (DBS) checks. DBS checks are carried out to ensure that staff are suitable to work with vulnerable adults in health and social care environments.

Staff were supplied with personal protective equipment (PPE). This included gloves, aprons and hand sanitizer. Staff we spoke with told us they were always able to ask for more PPE when needed. Staff had completed infection control and prevention training, and understood the importance of reporting outbreaks of flu and vomiting to the registered manager, so they could cover their work so as not to spread the infection.

Good

# Is the service effective?

## Our findings

The training matrix we viewed showed that all staff had engaged in the provider's regular training programme, which included specialised training such as dementia and end of life support. Mandatory training covered first aid, fluids and nutrition, manual handling, Mental Capacity Act and DoLs, safeguarding, medication, infection control, fire safety, catheter and convene care.

We spoke with staff regarding their training and all staff we spoke with told us they had received a full induction when they started working for the service. Due to the service only being in operation for a year, there was no requirement yet for any of the training to be refreshed. We looked at the induction staff were expected to complete before they started work and saw that it was aligned to principles of the Care Certificate. The Care Certificate is the government's recognised blueprint for staff who are new to the health and social care role. The induction usually takes place over a 12 week period and once completed is signed off by a senior member of staff.

Staff were required to complete competency assessments to ensure they were able to administer medication. We checked certificates for training courses staff had attended against the training matrix we were provided with and found that the dates matched for the courses attended. This meant that staff training was up to date. Staff attended formal supervisions every three months and received an annual appraisal.

We saw that new staff were subject to 'shadowing' (being paired with more experienced members of staff) and more regular supervisions. The registered manager informed us that this was because they wanted to ensure new staff felt supported. Staff we spoke with confirmed they received plenty of supervisions and support.

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. This is called the Deprivation of Liberty Safeguards (DoLS). There was no one subject to a DoLS during this inspection.

The registered manager explained the process they would follow if an application was required to safeguard someone in accordance with the principles of the MCA. This included involvement of the local authority if a DoLS needed to be applied for from the Court of Protection (CPA). The Court of Protection in English law is a superior court of record created under the Mental Capacity Act 2005. It has jurisdiction over the property, financial affairs and personal welfare of people who it claims lack mental capacity to make decisions for themselves.

We saw that people had been pre-assessed before their care package commenced. This involved the registered manager meeting people in their homes prior to the care package being put into place to look at what support they needed. People's care plans were completed in accordance with their diverse needs and preferences. For example, one person's care plan stated they wanted to continue to maintain their home to high standard.  This was recorded in their initial assessment and then further developed in their care plan.

People were supported with their choice of meals by staff. We saw that information about people, such as if they were diabetic or required a special diet, was recorded in their plan of care. Each person's food choice was different. We saw that one person liked to be supported to make burgers and stir fry's, while others chose to have microwave meals.

People were also supported make GP appointments if they felt unwell.

Good

# Is the service caring?

## Our findings

Everyone we spoke with stated they felt involved in their care and whenever the staff came to their home they chatted to them and involved them in their care. This shows that the staff were caring and respectful. People said that staff were very 'considerate in regard to their dignity and privacy.' One family member said, "They are respectful of me and I'm pleased with what they do for my [relative] and how they do it." Someone else said, "All of them [staff] do an outstanding job for my [relative]. They have a deep understanding and are compassionate."

We asked people about the need to respect privacy and dignity. People told us that staff respected their right to privacy and were mindful of this when providing personal care. People also told us staff made sure they had everything they needed before they left. One person said, "They [staff] always ask me is there anything else I would like them to do and they will do it for me.'

Each care record contained a section which addressed capacity, choice and control. People or their relatives, where appropriate, had signed the documents to say that they agreed with the contents. Care plans evidenced that people had been involved in discussions and changes to their care needs. People were clear that they had choices regarding how and when support was given. For example, one care record outlined how the person required specific support to transfer and what help was needed from staff in order to do this.

We asked the staff how they provided dignified and diverse care to people. One staff member told us they always knock on doors and say who it is before entering the person's home. Staff we spoke with spent time talking fondly about the people they supported and said they enjoyed their jobs.

It was clear from discussions that staff knew the people they supported well. When we spoke with staff they described the person and their needs in detailed, positive terms. Staff told us that they enjoyed providing support to people and were able to explain how they involved people in making decisions about their day-to-day care and support.

For people who had no family or friends to represent them contact details for a local advocacy service were made known to them via signposting from Synergy Homecare. There was no one accessing these services at the time of our inspection.

During the inspection we checked if confidential and sensitive information was protected in line with Data Protection. All information was safely secured at the registered address and was not unnecessarily shared with others. The 'registered address' is the address which has been registered with CQC and is the address where all records and documentations should be safely stored.

Good

# Is the service responsive?

## Our findings

Information we viewed in people's care plans evidenced that the service was person centred. Person centred means that the service revolves around the people they are supporting and not the other way around.

Equality and diversity support needs were assessed from the outset. Protected characteristics (characteristics which are protected from discrimination) were considered at the assessment stage and included age, religion, gender and medical conditions/disabilities. This meant that the registered provider was assessing all areas of care which needed to be supported and established how such areas of care needed to be appropriately managed.

Each care plan was written in the first person narrative, and contained information about the person, such as what they liked to do and how they liked to spend their time. For one person we saw that they liked to spend time on the computer. There was also information which stipulated what was important to the person, for example, 'I want to live in my own home, and remain as independent as possible.'

There was information around how to help the person do this, for example, please put the small table in front of me and I will clean my teeth. We also saw that this person had high standards of hygiene, and they wanted staff to support them with this.

There was specific information in relation to the person transferring, and what they can and cannot do for themselves. For example, the care plan stated 'I need you to use the slide sheet and ensure the sling is fitted under me.' The care plan stipulated what coloured loops the person needed to be used on the sling to transfer them to ensure comfort and modesty.

We saw for another person who had a Percutaneous Endoscopic Gastrostomy (PEG). This is an endoscopic medical procedure in which a tube (PEG tube) is passed in the person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. They had detailed information around how to 'flush' the PEG, and why this needed to be done at specific times throughout the day. We saw this was documented as 'Carers must ensure there is a kettle of water boiled before they leave so there is sterile water to flush the PEG.' This meant that each person's care plan was specifically written to ensure their choices and needs and met by staff.

There had been five complaints recorded since the service stated operating last August, and five compliments. We saw that all complaints had been resolved and people were satisfied with the response, we saw that some of the complaints related to missed visits which did not cause harm, so they were raised as a quality concern with the registered manager. We saw these were addressed with the staff involved through supervision and closed down. People that we spoke with said they knew how to complain.

Information was in place around people's specific communication needs. For example, we saw that one person communicated verbally, however they were unable to sign their own care plans due to medical

conditions, and this was referenced throughout their care plan. There was ongoing work within the organisation to ensure that information was made accessible for people. such as in alternative languages, braille, or large print.

Staff were trained in end of life care. People were supported to remain at home if they wished, supported by staff and other medical professionals. People had information in their care plans regarding what arrangements would be needed to be made in the event of their death. The service had recorded and responded to people's deaths appropriately and sensitively.

Good

# Is the service well-led?

## Our findings

There was a registered manager in post.

People we spoke with said the office staff came out regularly and spoke to them. On the whole, people were complimentary about the management of the service.

We looked at the quality assurance systems and processes to monitor how the service was operating and to drive forward improvements. A range of audits and checks were undertaken. The checks included care files, staff training and medication. In house auditing teams completed medication audits in people's homes each month. We checked these audits over the last few months and saw that where errors had been highlighted they had been promptly followed by robust action plans for the care staff to follow.

Completed medication administration records (MAR) were checked by the registered manager when they were returned to the office, as well as the in house auditors, as this had been a previous area of poor practice.

We saw that the medication audits had improved from a score of 75 per cent to 95 per cent in recent months. We checked the action plans from the previous months audits and saw that actions had been suitability assigned and checked off by the auditor at the next visit to ensure that the overall medication audit score improved.

The service worked well with the local authority and Continuing HealthCare (CHC). We saw that relationships had been developed, and this was demonstrated in the service's ability to ask for support to train their staff with regards to specific tasks, such as supporting people to receive nutrition through their PEG.

Additionally, we saw good examples of collaborative working with the occupational therapists (OTs). The OT's had been involved in competing a specific moving and handling risk assessment for someone who used the service with the involvement of staff from synergy. We saw that this risk assessment had been discussed with staff and signed by staff who provided care to that person. This shows that the service is working in partnership with other organisations to get the best possible outcomes for people.

We saw that an annual survey was in the process of being sent out. This had not been actioned yet as the service had only been open twelve months.

The service conducts regular face to face meetings with people which we saw evidence of in their care plans to ask about the provision of care and to ensure everything was working well for them. The yearly quality assurance survey has also not been completed yet, however, this was due to take place in the next few weeks.

As part of this inspection we discussed with the registered manager and area manager whether there had

been an opportunity for 'lessons learned' as part of their review of service provision. The area manager informed us that care packages were widespread in the area, and most of the recruiters were non- drivers which was challenging in terms of staff retainment. Therefore, the registered provider, in consultation with the area manager, decided to offer a more competitive wage to help attract drivers, as well as millage. This had helped staff retention in recent months.

Team meetings took place every month. We were able to see minutes of these, and saw agenda items such as staffing, call times, training, MARs and health and safety.

The staff that we spoke with were motivated to provide high quality care and understood what was expected of them. They spoke with enthusiasm about the people that they supported and their job roles. Each of the staff were positive about the support and quality of care offered by the organisation.

The service had policies and guidance for staff regarding safeguarding, whistle blowing, involvement, compassion, dignity, equality and safety. There was also a grievance and disciplinary procedure and sickness policy. Staff were aware of these policies and their roles within them. This ensured there were clear processes for staff to account for their decisions, actions, behaviours and performance.

The registered manager was aware what was required to be reported to CQC by law. As this was the services first inspection under the new provider's registration there were no requirements for previous ratings to be displayed.