Accord Housing Association Limited

Direct Health (Tyneside)

Inspection report

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22 May 2018
23 May 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 16, 22 and 23 May 2018. This is the first time we have inspected the service since it was registered in April 2017.

Direct Health (Tyneside) 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. At the time of the inspection there were 108 people receiving a service.

The service had a registered manager in place. 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 and their relatives told us people felt safe receiving support from staff. Staff had completed training in safeguarding and the registered manager actively raised any safeguarding concerns with the local authority.

Risks to people's safety and wellbeing were assessed and managed. Environmental risk assessments were in place in relation to people's own homes.

People's medicines were administered in accordance with best practice and managed in a safe way.

People, relatives and staff felt there were enough staff to meet people's needs. There were mixed views regarding the timeliness of calls but people relayed these weren't frequent issues. Staff were recruited in a safe way.

New staff told us they received a structured induction programme and they found this supported them in their roles and prepared them to deliver care to people safely. Staff received regular training, supervisions and annual appraisals to support them in their roles.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice. The principles of The Mental Capacity Act 2005 were applied appropriately in this service.

People were supported to meet their nutritional needs and to access a range of health professionals. Information of healthcare intervention was included in care records.

People and relatives felt the service was caring and staff were friendly. Staff treated people with dignity and respect when supporting them with daily tasks. People were supported to be as independent as possible.

People had access to advocacy services if they wished to receive support.

Care plans were in place for meeting each person's individual needs. They were personalised, detailed and included people's preferences. Regular reviews were carried out with people about their care and support.

People and their relatives told us they knew how to raise any concerns they had about the service. The provider had a complaints procedure in place and kept a log of any complaints received. All complaints received were investigated, acted upon and outcomes were fed back to complainants.

There were audit systems in place to monitor the quality and safety of the service. The views of people and staff were sought by the registered manager via annual questionnaires. All results were analysed and improvements were made where identified.

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 told us they felt safe receiving support from staff.

Staff knew how to protect people from harm.

Risks to people's health, safety and wellbeing were assessed and managed.

Is the service effective?

Good

The service was effective.

Staff received up to date training, regular supervisions and annual appraisals. Staff felt supported in their roles.

People were supported to meet their nutritional needs.

Staff supported people to access health care professionals.

Is the service caring?

Good

The service was caring.

People and relatives described staff as friendly and caring.

Staff treated people with dignity and respect.

People were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to them receiving support.

Care plans were personalised, detailed and regularly reviewed.

The provider had a complaints procedure in place. People and their relatives knew how to raise concerns and were confident in doing so.

Is the service well-led?

Good

The service was well-led.

The service had a registered manager.

Regular staff meetings and audits took place to monitor the quality of the service.

The views of people and staff were collected via annual questionnaires. The information was analysed and used to improve service provision.

Direct Health (Tyneside)

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 comprehensive inspection took place between 16 and 23 May 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is a community based service and we needed to be sure the office would be staffed. The inspection was carried out by two adult social care inspectors.

Inspection site visit activity started on 16 May and ended on 23 May 2018. It included a visit to the office location on 16 May 2018 to see the registered manager and office staff; and to review care records and policies and procedures. We made telephone calls to staff, people and relatives on 22 and 23 May 2018.

During the inspection we spoke with eight people and two relatives. We also spoke with five members of staff, including the registered manager, and five care workers. We looked at five people's care records and eight people's medicine records. We reviewed four staff files, including records of the recruitment process. We reviewed supervision, appraisal and training records as well as records relating to the management of the service.

Before the inspection took place we reviewed the information we held about the service. This included notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We used the information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection planning we contacted the local authority commissioners of the service, the local authority safeguarding team and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Good

Is the service safe?

Our findings

People and relatives told us people felt safe when receiving support from staff. One person said, "Yes, oh yes (I feel safe), they (staff) are very nice." Another person told us, "Yes I do (feel safe) in the majority of cases. I just get fed up with the new ones. They keep asking questions of what needs to be done." We spoke with the registered manager about the introduction of new staff to people and they explained that they are always accompanied with an experienced member of staff who people know.

Staff received regular safeguarding training to refresh their knowledge in how to identify potential signs of abuse and how to report any concerns. One staff member said, "If it was financial, physical and mental, signs of this would be if someone had no food in the house and if they were withdrawn or nervous. I would log in the person's care plan and ring the office and, if more serious, the police."

The registered manager had a safeguarding file in place that included a log of all safeguarding concerns identified, alerts raised to and concerns received from the safeguarding local authority, investigations and the subsequent action taken. Records showed safeguarding concerns were investigated and outcomes communicated to the person involved, if appropriate, and all other relevant parties. Where staff had been found to be at fault in some way, we saw the provider had taken actions included disciplinary action towards staff and referrals made to the disclosure and barring service about their conduct. There were no identified lessons to be learnt from records we reviewed.

The provider had safeguarding and whistleblowing policies in place and staff had continuous access to these via their work mobile phones. Staff we spoke with told us they were aware of the safeguarding and whistle blowing procedures. This meant staff had access to information to enable them to report any concerns via appropriate methods.

Risks to people's health, safety and wellbeing were assessed and managed. People had risk assessments in place where required. Risk assessments were stored within care files and were regularly reviewed. All identified risks had appropriate care plans in place which detailed how care was to be provided to mitigate those risks as much as possible.

In addition to risk assessments around people's individual needs there were also risk assessments around the internal and external environment of people's homes. The measures in place to minimise potential risks were recorded. Potential escape routes for people in the event of an emergency were also detailed.

Medicines were administered and managed in a safe way for those people who required support to take their medicines. Records confirmed medicines were managed safely. We viewed the medicine administration records (MARs) for eight people. All records were completed accurately, with staff initials to confirm medicines had been administered at the prescribed dosage and frequency. All staff administering medicines were trained and had their competencies checked to ensure those administering medicines were safe and experienced to do so. Regular medicines audits were carried out by care co-ordinators and registered manager to identify any errors in administering or recording. There was one error identified from

the medicines audits we reviewed. This was recorded, raised with the staff member involved and reported to head office as a 'near miss'.

The service recruited staff in a safe way. Applicants completed an application form in which they set out their experience, skills and employment history. All necessary pre-employment checks were carried out for each new member of staff including two references, proof of identification and an enhanced Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and minimises the risk of unsuitable people from working with children and vulnerable adults.

The registered manager explained the electronic system 'Staff plan' which they use to manage staff rotas and people's calls. They demonstrated how care co-ordinators arranged support for people to be provided by the same care staff members, where possible. The system automatically calculated travel time for staff who walked and staff who drove, and would not allow an entry to be made without that minimum time being allowed.

We viewed a selection of electronic rotas to check that enough staff were deployed to calls. Each rota contained a list of carers with times of calls. We received mixed views from people about staff timekeeping if they arrived on time. One person said, "Expect them when you see them." They went on to tell us staff were "really late occasionally" but "are there early enough" most of the time. Another person commented, "They come on time more or less, but sometimes are held up." A third person told us care staff didn't rush when supporting them and that there was enough time during their call for staff to meet their needs. A fourth person said, staff were usually on time and that "they have enough time to chat on".

Some staff told us there wasn't always time to travel to their next calls. We spoke with the registered manager about this and they explained a travel time function had recently been brought into use to ensure staff had enough time to travel from one person's home to another and to enable calls to be made in a timely manner.

No accidents or incidents had occurred since the service was registered in April 2017. The registered manager had a dedicated file in place to record any future incidents or accidents and told us she would monitor them on an ongoing basis for any potential patterns and trends.

The service had a business continuity plan in place for emergencies such as fire, loss of power or flu pandemic. This plan provided the registered manager with guidance to follow in the event of an emergency.

Care plans included instructions to promote infection control. For example, where to dispose of used incontinence aids, what colour sponges to use when washing different parts of people's bodies and details of Personal Protective Equipment (PPE) practices, such as the use of gloves and aprons. PPE helps prevent the spread of germs and protects people and care workers from infections.

Good

Is the service effective?

Our findings

We received mixed views from people on whether staff knew their needs and how to support them. One person confirmed staff provided support the way they liked and needed and told us staff updated their care plan during every call. Another person felt some staff knew how to support them but they weren't always confident that new staff could meet their needs as they didn't feel staff knew them well enough, having just met. The registered manager told us new staff were accompanied by an existing staff member who was familiar to a person when first attending their home.

Staff told us they received an induction when they first started working for the service and found it useful. New staff received a five-day induction which included mandatory training as well as health and safety and corporate policies and procedures. Staff then went on to complete a further 12 weeks induction course to complete the Care Certificate as well as some shadow shifts inclusive of spot checks by senior staff. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

The registered manager told us, "I arrange a meeting with new staff between six and ten weeks into their role to discuss how things are going and if they are getting on with their care co-ordinator. I also say I'll stay back if they'd like to have a chat with me one on one."

Staff told us and records showed that they regularly completed a range of training to enable them to carry out their roles effectively. One staff member told us they felt that training was thorough and at the right level. We reviewed training records and found topics included safeguarding, moving and assisting, medicines, health and safety, tissue viability and fluids and nutrition. Staff had also completed training specific to people's needs such as Huntington's Disease, Parkinson's Disease and stroke awareness.

Staff told us they felt supported in their roles and that they received regular supervisions and annual appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Records of these meetings showed they were used to discuss their performance and conduct as well as training, health and safety, policies and procedures and outcomes of spot checks carried out. There were also specific discussions around topics such as the correct use of equipment, medicines management and safeguarding. All agreed actions were recorded and revisited at the next supervision session.

The annual appraisal process involved the staff member completing a preparation form, reflecting on their performance over the past 12 months. As part of the appraisal meeting areas such as key strengths and any difficulties, knowledge and skills, personal development and objectives were reviewed. Agreed actions and objectives for the following 12 months were recorded. For example, to complete specific training.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA. Mental capacity assessments were decision specific and included best interest decisions were appropriate. For example, for specific care plans. Staff we spoke with understood the principles of MCA and people making choices and decisions regarding their care.

People were supported to meet their nutritional needs, where required. Care plans contained people's food and drink preferences. For example, one person's nutritional care plan stated, "I normally have a sandwich with a choice of filling. I sometimes have a yoghurt for dessert. I like my coffee to be luke warm with 1 sweetener in a cup with straw."

Records showed people were supported to access external professionals to monitor and promote their health. People's care plans contained records of interventions with pharmacists, GPs, district nurse, nutritional nurse and dietician, bowel and bladder nurse and other health professionals involved in their care.

Care records demonstrated how a person's physical, mental and social needs were assessed when they started using the service and then on a regular basis. Care records contained information which considered current legislation and national guidance. For example, NHS guidance for Percutaneous Endoscopic Gastrostomy (PEG) feeding and maintenance.

Good

Is the service caring?

Our findings

People told us they were comfortable with staff and described the service as caring. One person said, "In the main the girls are wonderful once we get used to each other and I wouldn't be without them." Another person told us, "I get on well and chat with the carers. I know all about their families and where they live." A third person commented that they found care workers okay and they chatted with them. A fourth person said they were a "crew of lovely lasses". A fifth person told us, "The girls are lovely."

The service provided people with a 'service user guide' when they first started using the service. The guide contained information about the provider and the service. This provided contact details, a guide to what to expect from the service and how to raise any concerns, as well as people's rights.

Staff treated people with dignity and respect. One person said, "I feel very respected and I get on extremely well with the carers and I feel very well looked after." Another person told us, "Carers are always very respectful and gentle" when providing support such as applying cream to their body. Staff we spoke with were able to explain to us how they respected people's privacy and dignity when supporting them. For example, explaining what they were going to do and seeking permission to carry out an action in advance. One staff member said, "When I am supporting people I ensure that people are covered over and close curtains and doors."

People's needs had been assessed and appropriate plans of care had been implemented. We viewed people's care records and noted staff recorded daily notes. Records included details of support provided to each individual as well as people's general mood and if they showed any signs of feeling unwell.

People communicated their wishes to staff in different ways, for example, pictures and gestures such as pointing and blinking. People with communication needs had plans of care in place to guide staff how best to communicate with them and what different gestures may mean. One person's care plan stated they used an electronic device "to help communicate what I want". The care plan also guided staff to use a picture book, give the person options and ensure they give them time to answer. The person could also use a note pad and pen to communicate their wishes if their electronic device stopped working.

People were supported to be as independent as possible and their capabilities were included in their care files in social care assessments and support plans. For example, one person's personal care plan stated, "I can wash my top half myself but will need assistance to wash my back, feet and hair." Staff told us they asked people if they wanted to do anything themselves prior to providing support, to promote independence.

Most people receiving support from the service could express their own views and opinions about their care and about the service in general. Where necessary, relatives acted on behalf of people. The registered manager told us at the time of the inspection that no one was actively receiving support from an advocacy service. Advocates help to ensure that people's views and preferences are heard. The registered manager was able to explain how advocacy services would be arranged should they be needed. They said, "If anyone

needed or wanted an advocate I would refer them to adult social care."

The provider had people's advocacy and rights embedded in their 'Relationships with Service Users' policy as well as their service user guide provided to every person. It also contained details of independent local advocacy services as well as Independent Mental Capacity Advocates (IMCAs). An IMCA is someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them.

All files containing confidential information including people's care plans, archived records and staff files were securely stored in locked cabinets in the office. All computers were secured by passwords and emails we saw demonstrated practices used to protect personal information about people who used the service. This meant people's private information was stored securely and confidentiality was maintained.

Good

Is the service responsive?

Our findings

People had their needs assessed prior to receiving care and support. Assessments were used to gather personal information about people to help care co-ordinators and the registered manager understand their needs and to inform plans of care. Information gathered included life history, relationships important to people and hobbies/interests. Assessments also included daily living needs, medicines and communication needs.

People had a range of care plans in place to meet their needs identified in their pre-assessments. Areas covered included communication, personal care, medicines, nutrition and hydration, skin integrity and moving and handling. Care plans were detailed, personalised and included people's choices, preferences, likes and dislikes. For example, one person's personal care plan stated, "Usually I like to use dove shower cream for my body and for my lower parts to be washed with feme wash. Please offer me a face cloth (when washing hair) so I can cover my face, as I don't like the water going in my eyes." People were provided with personalised care. One person said, "I like my bath deep and hot and carers always draw the bath the way I like it."

Care plans contained detailed information to guide staff about how to meet the specific needs of each individual from the first point of contact at the person's front door. For example, to obtain the door key from the key safe and enter the person's home via the front door, calling to the person to alert them of their arrival.

We received mixed views from people regarding being involved in reviewing their plans of care. One person told us about a time they weren't happy with their care plan and got staff to re-write it to reflect what they wanted. A second person told us "Someone did ring up to discuss the care plan but no one has been out to change the book." A third person told us their care plan had never been reviewed. A fourth person commented that a care co-ordinator from the office "occasionally comes every so often" to review their care plan. A relative told us that their family member's care plan was looked at regularly.

The registered manager told us care co-ordinators reviewed people's plans of care in the homes with their involvement, or the involvement of relatives if people were supported by relatives to communicate their wishes. Care plans we viewed contained person-centred reviews that care co-ordinators completed with people in their homes which looked at all aspects of the care they received. For example, assessments, outcomes and equipment. Care plan reviews we saw had been signed by the associated person as well as the care co-ordinator. Any actions identified during reviews were recorded and signed off when completed. Examples of actions included a re-assessment required of a person's needs and revision of a person's care package to include additional hours.

The registered manager told us there was a chip in people's care plans which staff scanned with their phones when they arrived at a person's home. This function then automatically updated the system with the date and time of the staff member's arrival to the person's home. Staff could also access their individual working rotas through the application on their phones which meant any changes or updates to rotas were

immediately available to staff.

People told us they were asked if they were happy with the service or if they had any concerns. One person said, "One lass came out and asked me if I was happy with everything. (I have) no complaints whatsoever." Another person told us, "I cannot fault them." A third person told us about an issue they had with the service. They spoke with a member of the office staff about the issue and immediate action was taken to resolve the matter. A fourth person told us they would have no hesitation in raising a complaint if they had any concerns.

The provider had an up to date complaints procedure in place which included contact details for the provider. This procedure was provided to each person when they started using the service. Other information included contact details for the local authority safeguarding team, North Tyneside primary health trust, the local ombudsman and the Care Quality Commission should people or relatives wish to share their views or experiences with those organisations. The registered manager maintained a file of all complaints received. Records showed the service had received eight complaints in the last 12 months. All complaints were acknowledged, fully investigated and subsequent action taken. For example, discussed in a staff meeting, share best practice and change care staff supporting a person.

At the time of the inspection no one was receiving end of life or palliative care. The registered manager told us they worked alongside Marie Curie and had previously supported people on end of life care. Marie Curie is a charity which supports people with palliative and end of life care.

Good

Is the service well-led?

Our findings

There was a registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The registered manager clearly understood their responsibilities as a registered manager and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

We received positive feedback from staff regarding management. One member of staff said, "Care co-ordinators are very supportive, helpful and knowledgeable." Another member of staff said, "[Registered manager] is both approachable and supportive. She is nice. I would have no bother raising issues with management." A third member of staff commented, "[Registered manager] is fab." A fourth staff member said, "I didn't feel supported at the last company I worked for but I genuinely like this one."

During the inspection we asked for a wide variety of records and documents from the registered manager. We found records were easily accessible, stored securely and well maintained. Throughout our inspection we found the registered manager and staff to be open, approachable and cooperative when we spoke with them.

The service had out of hours arrangements in place to ensure staff members were able to contact a member of the management team if necessary. The registered manager informed us that out of hours arrangements were organised on a weekly rolling rota between themselves, the care coordinators and other senior staff. The allocated senior person covering had office phones diverted to them and had a laptop with remote access so they could access electronic records such as rotas. The registered manager told us if on call staff could not deal with a query or issue they would "escalate it to me" and went on to tell us, if needed, they would escalate the issue to their line manager if they were unable to resolve the matter.

Regular meetings took place between office and care staff to discuss all aspects of the service. We reviewed minutes of meetings which showed discussions included recruitment, work schedules, systems, health and safety, safeguarding, records, care plans and medicines. Other discussions were specific to the designated areas. For example, changes in care co-ordinators or specific difficulties staff were experiencing when supporting people. There was also an opportunity for staff to raise issues under 'any other business'. Staff told us they attended regular meetings. One staff member said, "Staff meetings are held usually every two to three months but I would always shout up in between (if I had any issues)." Another staff member told us, "We have staff meetings every 12 weeks."

Staff were asked to complete a survey each year to give their views on working for the service and how support was delivered. Feedback from surveys received in May 2018 were mainly positive, although there were some issues raised. For example, not always having sufficient time to get to the next call. The registered manager had arranged to meet with staff who had raised issues to explore the problems/issues further and discuss possible solutions. Positive feedback was received around availability and quick responses from office staff and the quality and frequency of training.

People were asked for their views via an annual questionnaire. This asked their views about all aspects of the service. Annual questionnaires were sent out at the end of 2017 to every person with 44 completed surveys returned. Feedback received was mostly positive with overall service ratings being mainly 'Excellent' or 'Good' with none less than 'Satisfactory'. Those people who raised any issues received a person-centred review in their homes to discuss the issues and resolve them. For example, one person wanted additional time on their lunch and tea-time calls. Records showed these call times were increased by 15 minutes each.

The registered manager told us they were also planning to set up regular surgeries where people could either meet staff or receive a visit in their home. They told us that the aim of the meetings will be to give people more opportunities to raise any issues and discuss any concerns. The registered manager explained this would enable them to act quickly in respect of any concerns or issues in the first instance to reduce the likelihood of them escalating into official complaints.

The registered manager completed a number of audits around the quality and safety of the service. These included care plan audits, daily records, and medicines management. All findings were recorded as well as any required actions. During the inspection we saw that actions had been completed and signed off where identified.

The service had received seven compliments in the form of 'thank you' cards, telephone calls and emails in the last 12 months from people, their relatives and professionals such as social workers. Comments included, staff "had been a breath of fresh air and happy to help complete all the tasks needed on the visit," staff were "very supportive" as well as "caring and professional," "staff are marvellous," and describing staff as going "above and beyond."

The registered provider sent out quarterly newsletters to every person who received a service. information included office staff and their roles, summary of feedback received from surveys returned and a staff member winning a home carer award.

The registered manager told us a care worker had received a regional and national Home Carer Award at The Great British Care Awards in November 2017 and February 2018. The Great British Care Awards are a series of regional events throughout England and are a celebration of excellence across the care sector. The purpose of the awards are to pay tribute to those individuals who have demonstrated outstanding excellence within their field of work.