Your Homes Newcastle Limited

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Inspection report

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Overall summary

This was an announced inspection which took place over two days, 4 & 5 August 2015. This is the services first inspection since registration in April 2014. As the service had only started operating two months before this inspection there was not enough evidence, so the service was inspected but not rated.

Your Homes Newcastle Limited (YHN) is a domiciliary care service that is registered for the regulated activity of personal care. The service provides care and support to people in their own homes. It provides a service to 43 people at Trevelyan Court, a housing with care scheme. YHN provides the service at Trevelyan from 8pm to 8am. Another registered domiciliary provider covers the day time activity and support. Trevelyan Court is made up of flats with a secure entry system, and bungalows.

There was a registered manager in post since 2014. 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.

As the service had only recently started operating there was a lack of evidence in order to rate the service. With the provision of care being shared with another provider, who provided most of the personal care, YHN provided mainly responsive night time cover. We could see from records and talking to staff that most of the planned care was arranged via the handover at 8pm between the day time provider and YHN staff.

The service had taken steps to make sure people were safe in their new accommodation, that risks had been assessed and that snags in the new building were quickly resolved.

There was enough staff to meet the needs of people and respond to requests for support and respond to changes in their needs flexibly.

Staff had been trained into their new roles and were supported through induction and regular supervision from senior workers. There were some areas of training that had not been identified by the provider and they agreed to address this.

The service liaised with and assisted people to access health care professionals and worked alongside them to support people.

Summary of findings

The staff had organised activities and events for people using the service based on their wishes, needs and preferences.

Care plans were not detailed enough to describe how best to support people or how they had been involved in their assessment and their consent had been given.

The service had a registered manager and senior staff who were visible in the service to staff and people. Not all people were clear about the differing care providers.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe. Staff knew how to work to keep people safe and prevent harm from occurring. The staff were confident they could raise any concerns about potential abuse or harm, and that these would be addressed to ensure people were protected from harm.

The staffing was organised to ensure people received appropriate support to meet their needs. Recruitment records demonstrated systems were in place to ensure staff were suitable to work with vulnerable people.

People's medicines were managed well. Staff were undergoing training and were monitored to make sure people received their medicines as required.

Is the service effective?
The service was mostly effective. Staff received on-going support to ensure they carried out their role effectively. Formal induction and supervision processes were in place to enable staff to receive feedback on their performance and identify further training needs. Staff attended the provider's induction and training.

Arrangements were in place to request support from health and social care services to help keep people well. External professionals' advice was sought when needed.

Staff required training on the Mental Capacity Act.

Is the service caring?
The service was caring. People could make choices about how they wanted to be supported and staff listened to what they had to say.

The staff knew the care and support needs of people and took an interest in people and their family carers.

Is the service responsive?
The service was not always responsive. Care plans did not contain enough detail of the planned care that was to be delivered.

People told us that staff responded to requests for assistance but records did not always contain the detail of how to provide this support.

Is the service well-led?
The service was well led. The service has a registered manager who had a clear vision for how the service would develop. There were systems in place to make sure the staff learnt from events such as accidents and incidents.

People were not always aware of who the care provider was at night time and the difference between the day time provider at Trevelyan Court.

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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.

This inspection took place on 4 and 5 August 2015 and was announced. We gave the service 48 hours' notice as it is a domiciliary service and we needed to be sure people would be available. The visit was undertaken by an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience telephoned people using the service, their families and carers over the 9, 11, 12 and 13 August 2015.

Before the inspection we reviewed information we held about the service. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with four staff including the registered manager, nine people who used the service or their relatives if they were unable to communicate via phone. We also spoke with two external professionals who regularly had contact with the service.

Five care records were reviewed as was the staff training programme. Other records reviewed included, near miss/ incident reports, handover records, one staff's recruitment/ induction/ supervision and training files, and staff meeting minutes. The registered manager's action planning process was discussed with them as were meetings with the other provider at Trevelyan Court of personal care and commissioners of the service.

Is the service safe?

Our findings

People received safe care, as well as advice and support to keep themselves safe from potential risks. Staff told us they had attended safeguarding adults training. Training records confirmed this. Staff we spoke with knew how to raise any concerns they had about people's safety and thought they would be responded to. We could also see that Your Homes Newcastle (YHN) had liaised with the Fire Service to gain fire safety risk assessment advice. This led to one client being issued fire retardant bedding to reduce risks when smoking in bed. Trevelyan Court was purpose built and had secure access doors to the main building, and people in each flat or bungalow could call the staff office where the YHN staff were based at night.

One person told us they had experienced problems at night with people from the community knocking on doors. They told us the staff had responded by checking the area and offering them re-assurance. They told us "We had a bit of bother with youths knocking on doors at about 2.00am and the agency dealt with it for us after we phoned them." We could see from a notification sent to us that the police had been called once after a tenant witnessed a disturbance in the surrounding area.

Care plans we reviewed contained risk assessments around the potential risks whilst providing personal care, such as moving and handling. These were written jointly with the other care provider. Staff we spoke with were aware of the content of these risk assessments and knew that if people's needs changed they would need to be updated.

Records showed that YHN liaised with the landlord of the property to raise any issues or to report repairs needed. The service also had a contingency plan to respond to any possible emergencies.

The registered manager told us how they would keep records of any accidents or incidents. They had two recent 'near misses' and they showed us the process they went through to manage these and reduce the likelihood of reoccurrence.

There were also two seniors who worked alongside the registered manager to manage the team and the service. Staff told us they could contact a senior through the day, or an on-call staff member at night.

During the hours the service was provided there were two staff on duty. From talking to one of them and looking at records it was clear they were able to respond to calls promptly, as well as carry out routine tasks in the service, such as security checks. One person told us that "They (Staff) answered the call bell very quickly" and "Felt safe with them coming in at night."

We saw that staff had followed a common recruitment process that included an interview, the checking of references and a disclosure and barring service (DBS) check. The DBS carries out criminal records checks to help employers make safe recruitment decisions. We looked at recent recruitment files and spoke to staff who confirmed the process.

Records told us that staff sometimes prompted people to take their medicines, this could vary over time and we saw that the handover book recorded any changes in peoples support needs. One person told us "They (Staff) check every night to see if I have taken my insulin and tablets because I have short term memory loss. They are really good to me." Medicines records were stored in each person's accommodation and staff completed these records if they were responsible for supporting people. Staff told us they were booked to attend training on safe handling of medicines and could tell us the process they followed to support people.

Is the service effective?

Our findings

We saw in training records that staff had attended key training before starting work. Some of the staff were new to care work and were able to tell us how the training provided had helped them make the transition to being a carer. They had attended key training such as health and safety, moving and handling, person centred care, as well as the provider's core training. Staff told us they had also attended specialist training about hoarding of possessions. Staff told us that as part of their induction they had shadowed experienced staff from the other provider and read the care plans. Staff were not able to work on shift until they had been signed off by a senior staff member as competent.

We saw that staff were supervised regularly by the senior staff. The provider had a clear policy of regular supervisions and an annual appraisal. The seniors we spoke with told us that they would call at the service in the evening to check in with the staff. Staff we spoke with told us they could contact a senior or 'on call' worker if they had any issues and were also supervised formally as part of their induction process.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) Staff we spoke with had an understanding of the issues relating to mental capacity, but had not undertaken any specific training on the subject. When we brought this to the attention of the registered manager they advised they would seek appropriate training immediately for their staff.

People were usually supported with their shopping, cooking and diet by the other day time provider. We talked to YHN staff and they told us they did help people prepare meals and drinks if they requested.

We saw evidence of good collaboration between the service and the local GP and community health professionals. We saw there had been a recent issue with one person's behaviour. Staff had worked with the persons community psychiatric nurse and sought their advice and input to manage the situation. Staff we spoke with told us they would contact out of hours GP and other medical services if the need arose.

The premises were purpose built with a communal lounge and during the day access to a café. Peoples own flats or bungalows had a call bell system in place connected to the staff office and the 'on call' provision at night.

We recommend that the provider reviews their training for The Mental Capacity Act 2005.

Is the service caring?

Our findings

The provider told us via the provider information return that they kept all positive feedback from people on a staff notice board. We saw this when we visited the service and could see that people had left cards expressing their thanks and gratitude for the service provided. It was difficult to identify to which provider they were referring to as they did not state if it related to YHN or the other provider. When we spoke with people over the phone it was difficult for them to identify which provider's staff they were talking about when we asked if they were caring. We did not receive any negative comments about staff during our calls.

One staff member was the dignity champion and we spoke with them about their role. All staff had attended equality and diversity training and the champion saw a key part of their role was to build on the training by supporting staff to further develop awareness.

The registered manager told us they planned to organise customer consultation events, facilitated by the provider's customer involvement team. Meetings had already been held with people at Trevelyan Court to gather feedback and look at issues that arose moving into the new service.

Is the service responsive?

Our findings

The registered manager told us that they were working with the other care provider to complete a one page profile for each person. However care plans contained minimal information, with times of planned support identified, but not giving much detail about how people liked to be supported. It was not clear if the person had given their consent to their care plan or how they had been involved in it.

From looking at records of activity at night we could see that the service had responded to peoples rapidly changing needs. For example a district nurse had concerns over a person's ability to mobilise to the toilet. Staff were able to put a program of support into place immediately to support this person until their condition improved. Another example was where the staff supported a person with mental health issues to attend hospital for a medical emergency. Due to staff support they were able to cope with a very stressful episode.

One person told us about their experience of the service and the speed of their response. "They come and see me all the time to see if I am alright and help me. Friendly staff and they answer the call bell quickly."

YHN staff had taken time to develop activities and had recently supported people to attend a local dementia friendly cinema event. Following a request from two people the Newcastle Riverside Falconry Centre attended and provided a demonstration at the scheme. This was well attended and included members of the local community.

The service had received no complaints since starting, but people had been given information about how to raise a complaint as part of their welcome. This information was also available in the service itself.

We recommend that the provider reviews their care planning process and how they gain peoples consent.

Is the service well-led?

Our findings

Feedback from people was that they thought the service at Trevelyan Court was well led. But they were unable at times to differentiate between the two providers at Trevelyan Court.

The registered manager and staff we spoke with were clear about the culture and values of their service. Their aim was to assist people to remain in their own accommodation at Trevelyan Court for as long as possible, and to reduce admission to full time care. The registered manager sent us information about the development of the service alongside commissioners to achieve this aim and provide a flexible response to people's needs. The registered manger had commissioned external research to look at ways to develop links with external agencies and improve collaboration with them. There was a high level of interaction and joint work between the two care providers at Trevelyan Court, sharing skills and expertise.

The two senior staff worked alongside the other care provider at Trevelyan Court to monitor care plans and records to check for issues. They worked together to ensure they learnt quickly in response to the challenges of opening a new service.

The two seniors with day to day responsibility for the service were visible to people and staff and undertook checks in the service alongside the other provider. The staff we spoke with told us they felt supported by the registered manager and two seniors' staff.

The registered manager was aware of their responsibility to send in statutory notifications to the CQC as required.

The provider organisation was inspected annually by the Telecare Services Association and has been awarded platinum status, which is the highest level of accreditation.