Sunderland Home Care Associates (20-20) Limited

Haddington Vale Extra Care Scheme

Inspection report

Haddington Vale, Knightswood
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Sunderland
Tyne And Wear
SR3 2FD

Tel: 01915255852

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 2 and 6 October 2017 and was unannounced. Haddington Vale Extra Care Scheme is a domiciliary care provider registered to provide personal care for people living in an extra care scheme. At the time of this inspection 46 people were using the service. This is the first time the service has been inspected.

This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.
Not everyone using Haddington Vale Extra Care Scheme receives the regulated activity of personal care; CQC only inspects the service being received by people provided with 'personal care'; such as help with tasks related to washing, dressing and eating for example.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We found the service had breached a number of regulations. The provider failed to identify, assess and manage risks to the health and safety of people of using the service. Medicines were not managed safely. Care plans were not specific and lacked detail. We also found that the provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

The service ensured trained staff were deployed to support people. The provider had a robust recruitment process in place, with staff being fully checked before starting working with people.

There were enough staff employed to carry out all the visits that were required. People told us they were regularly supported by the same team of care workers.

People were supported to maintain good health and access to healthcare professionals.

People were happy with the care and support they received and spoke positively about the staff. People told us they were treated with respect and dignity with staff being kind and caring.

Processes and procedures were in place to ensure people were protected from abuse and harm. Staff spoke confidently about the actions they would take if they thought a person was at risk of harm.

People were involved in the decision making about their care and treatment. Feedback was regularly sought from people using the service and staff.

People were not always supported to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible and the policies and systems in the service support this practice.

Staff said they felt supported by the branch and assistant manager. Staff we spoke with confirmed they could raise issues with the management and said they were "approachable".

Following this inspection, we invited the provider to meet with us to discuss our findings and to seek assurances about how they planned to improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people were not always identified and where risks had been recognised these were not fully mitigated against.

The service did not ensure medicines were administered in the right way or at the right frequency, in line with the instructions on people's prescriptions.

Staff demonstrated a good awareness of safeguarding.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had not completed MCA assessments and 'best interests' decisions for people who lacked capacity to make decisions for themselves.

Training, supervisions and appraisals were up to date and monitored by the service.

People were supported to maintain their diet and hydration.

Is the service caring?

Requires Improvement

The service was not always caring.

People were encouraged to be as independent as possible.

Staff did not always discuss people in an appropriate manner.

Staff had not received end of life training.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not personalised and did not detail the support staff were to provide.

People were involved in all decisions about their care and support.

The provider had a system for the recording, investigation and analysis of complaints

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

The service had a clear management structure in place. Staff said they were happy working at Haddington Vale.

People and staff were encouraged to express their views about the services.

Haddington Vale Extra Care Scheme

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 2 and 6 October 2017 and was unannounced. On the first day the inspection team consisted of one 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. On 6 October 2017 two adult social care inspectors completed the inspection.

We reviewed other information we held about the service, including any statutory notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. Before the inspection, we also contacted the local authority commissioners for the service and the local authority safeguarding team to gain their views of the service provided.

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.

We looked at five care records for people who used the service. We examined documents relating to recruitment, supervision and training records and various records about how the service was managed.

We spoke to eight people who used the service, the registered manager, branch manager, assistant manager, compliance officer and four staff members.

Requires Improvement

Is the service safe?

Our findings

Identified risks were not assessed and managed appropriately. Where risks had been identified these were not fully mitigated against. For example in one person's care plan reference was made to the person having problems swallowing, no choking risk assessment was in place to help staff reduce this risk. When people had changes in their needs risk assessments did not reflect this. For example, an Occupational Therapist had introduced the use of a stand aid sling however the moving and handling risk assessment overall summary reported that person was a low risk which was incorrect and made no mention of the mobility aid.

Medicines were not always managed safely. The service identified the level of support at the initial assessment and a risk assessment was put in place. However changes to person's needs was not reflected in their risk assessment or reported in their visit information. For example staff had reported one person had been disposing of their tablets. We noted this information was not identified as a risk and no changes to the risk assessment had been carried out.

PRN (as required medicines) protocols were not in place. PRN protocols assist staff by providing clear guidance on when PRN medicines should be administered and provide clear evidence of how often people require additional medicines such as pain relief medicines. We found people's medicines were not always administered in line with the directions on their prescription. For example one person's pain relief medicine required to be taken at every four to six hours. We saw this had not happened and some medicines were taken with a shorter gap of four hours, one being only two hours and twenty minutes.

We discussed this matter with the branch manager who advised they would look into the matter. They also advised that PRN protocols were to be introduced but were not in place during our inspection.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The branch manager told us staffing levels were set by the needs of the people using the service. The service ensured it had the right mix of staff to support people's needs. People we spoke with did not raise any concerns about the staffing levels. One person told us, "They come on time." Another person said, "I get the same carers they are a lovely bunch." One staff member told us, "Because we are located in the building people know us better. I know people have certain calls but I don't mind popping up to support them downstairs to an activity." The branch manager told us, "We are in early so if anyone is sick I or [an assistant manager] can support people. We can also use staff from our other services."

People told us they felt safe at Haddington Vale. One person commented, "Feel very safe" and "Would be in a sorry state without them". Another person said, "My family are happy I'm here."

The provider had systems in place to make sure people were protected from abuse and harm. However not all concerns were fully investigated. The provider had recently employed a compliance officer who had created and introduced a new safeguarding audit which analysed the safeguarding concerns identifying trends. The branch manager advised all new safeguarding concerns will have a written investigation and

conclusion. Staff had completed safeguarding training and were able to describe confidently what action they would take if they had safeguarding concerns.

The provider operated a safe and robust recruitment process. Pre-employment checks were conducted including obtaining full employment history, checks on identification, references from previous employers and Disclosure and Barring Service (DBS) checks. DBS checks help employers make safer recruitment decisions and help to prevent unsuitable people from working with vulnerable adults. The provider had also asked staff to sign up to the DBS update service. The update service lets employers check the status of an existing DBS certificate. This means the provider had access to current information ensuring people remained safe.

A business continuity plan was in place to ensure people would continue to receive care following an emergency. This described potential issues such as lack of staff and had solutions readily in place.

Requires Improvement

Is the service effective?

Our findings

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.

The manager advised a number of people were living with dementia and had varied levels of capacity. We did not see evidence of MCA assessments and subsequent 'best interests' decisions being carried out for people who lacked capacity to make decisions for themselves. This meant records did not consistently show which decisions people could make for themselves, and which decisions needed to be made on their behalf in their best interests.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The provider offered a training programme which included moving and handling, safeguarding, dementia care, mental capacity act, medicines and first aid. Staff we spoke with told us were positive about the training available. One staff member, "I think the training is good, if I was lacking in an area I would ask." The branch manager told us that they had identified a number of people with diabetes so the service was currently looking at specific training and developing risk assessments and care plans in relation to supporting people with this condition more effectively.

Supervision and appraisals were up to date. The branch manager advised staff received six supervisions a year and an appraisal annually. Supervisions were conducted by the branch manager and assistant manager. Staff confirmed they regularly took part in supervisions and appraisals. One staff member said, "Supervisions give us a chance to have a chat, I feel listened to."

Staff supported people by preparing meals or supporting people to the communal dining room. One person said, "They look after me well." Another person told us, "They are very helpful." Care plans did not describe the support people required with eating and drinking, including any risks associated with their nutrition. For example, one person's plan stated, "Support [Person] with tea/snack and encourage fluids." We discussed this with the branch manager. They stated, "People tell staff what they want doing." We discussed occasions when people living with dementia might not be able to advise staff and the importance of capturing people's wishes and preferences.

The majority of people organised their own, or were supported by family members to gain access to healthcare professionals. The branch manager told us they supported people and their families to get support from the correct service. We noted in one person's daily records a staff member had made reference to a mark on the person face and to keep an eye on it. When we consulted the accidents and incidents and daily handover records we found no record of this concern being passed on. We discussed this matter with the branch manager who advised that although the person had capacity the matter should have been

documented including what, if any, action staff had taken in response.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us they were happy with the service. One person said, "They treat me like a princess." Another person said, "Brilliant, the carers are brilliant I can't speak more highly of them. They only do good things."

We noted in the office a noticeboard which had recorded showers/baths then numbers. We enquired what the numbers referred to. The branch manager advised that the numbers referred to people requiring support and due to confidentiality they used the room numbers. We questioned this recording of information and the branch manager reassured that people were not commonly referred to by room number. On the second day of our inspection we witnessed staff members discussing people by their room number rather than name. The branch manager advised the matter would be discussed with all staff.

People were encouraged to be as independent as possible. One person told us, "I have my independence here. I can do what I wish but I know they carers are there if I need them." Another person said, "I do most of it myself but the girls help me when I struggle."

People spoke positively about the care and support their received. No one we spoke with raised any concerns about missed calls or rushed calls. One person said, "I really like the girls, some sit and have a chat." Another person said, "They let me know if they are a little late but I know they are coming."

People told us about the importance of having the same staff. One person said, "I know the girls who come to see me." Another person told us, "We have a lovely relationship with the staff and they are always laughing together." We observed staff members engaging with people in the communal areas as they went about their duties and on their breaks. Staff were able to tell us about people's families and their life stories.

Staff treated people with respect and dignity. One person told us, "They explain everything to me as they are doing it and always come straight away if I have to use my button." Another person said, "Carers treat me with dignity." Staff were able to describe how to maintain people's privacy and dignity. One staff member said, "I always ask the person for permission before supporting them, I try to make them comfortable." Another staff member told us, "Everyone is different. [Person] prefers older carer so we try to get the older staff."

We found that staff explored people's wishes with regards to end of life care. This was done as part of an initial care assessment and asked questions regarding people's end of life plans. The branch manager told us they wished to expand on the delivery of the support the service offered in this area and two staff members had expressed a desire to complete specific training in end of life care. The service also promoted 'Let's talk about it- Dying Matters.' This is a programme encouraging people to create their own individual end of life plan to ensure their final wishes are captured and respected.

The registered manager advised that no one was currently using the service of an independent mental capacity advocate (IMCA). The service clearly displayed local advocacy services in their service user guide

which people received when they started receiving care at Haddington Vale.

Requires Improvement

Is the service responsive?

Our findings

Care records comprised of an individual person centred care plan, risk assessments and a daily visit record. The individual person centred care plan had questions which were based on what the person could do for themselves, for example, "Can you dress yourself?" "Do you have problems with your bladder?" and "Can you manage the stairs?" Answers gathered were yes or no with a basic response for example, "Requires support from two staff."

This information was then transferred to daily visit record which detailed tasks to be completed during visit. These comprised of a couple of short directions for staff to follow and every day was the same. For example, [Person] will be in the lounge on arrival" and "Encourage [Person] with fluids." There was no information on how care workers were to support people or details about people's preferences and how they wished to be supported.

We noted the individual person centred care plan asked if the person required an interpreter or signer however it did not enquire if the person preferred any other type of communication for example flash cards of images or easy read format. One person had a visual disability and another person had difficulty with hearing we noted this information was not mentioned in their daily visit record. Care records were not specific and contained very little detail. We discussed the issues we identified with the branch manager who advised us that the care plans were being currently reviewed.

The service had conflicting information in regard to people's records of Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR). It was not clear who had a DNACPR in place and if it was in date. The branch manager told us, "Families usually have them in the room." We discussed the importance of staff being aware of people's wishes and the branch manager advised they would review their process of gathering and monitoring of information. This meant staff did not have access to up to date information about how people should be supported and cared for.
Care records outlined the level of support a person required with their medicines but did not report on how the person liked to take their medicines. Daily visit information stated, "Check MAR chart and prompt meds, "and "Level three medication prompt."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints procedure which was included in the service users' guide given to people at the start of their care package. This outlined how a complaint would be investigated and the timeframes for actions to be completed.

People we spoke with told us they had no complaints about the care and support provided. One person said, "No complaints, lovely girls all of them." Another person said, "I would just tell them if something was wrong." Staff supported people downstairs to take part in activities arranged by the housing provider.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have effective systems to ensure it was able to monitor and assess the quality of their service. A compliance officer had recently been recruited. Although they had only been in place a short time they had implemented a series of quarterly audits. These included accidents and incidents, care planning and safeguarding. Information was analysed and any points were given as actions to be completed with nominated individuals responsible for their completion. For example the accident and incidents audit identified that the accident book was not capturing enough information. The action point was for the issue to be discussed at the next staff meeting and introducing a new accidents log.

We found that the issues we identified during our inspection were not recognised or always picked up within the quality monitoring systems employed. For example the lack of risk assessments, no evidence of MCA assessments and 'best interests' decisions being carried out and the lack of information in regard to people's records of DNACPR. A care plan audit had recently been introduced however we questioned its effectiveness. Care plans where we had identified issues had been through the auditing process and the issues had not been highlighted .

Whilst the service had acknowledged the need for improvement within its care plans, we noted audits had still not identified the issues we had discovered in relation to care planning and assessment. We questioned the effectiveness of the new audit with the manager. They told us it had only been in place a short time. The service had an established management structure. The registered manager was responsible for four services including Haddington Vale. A dedicated branch manager was in place with an assistant manager and both also managed another local service.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The branch manager told us they felt totally supported by the registered manager. The branch manager told us, "I have an open door policy, I am here or [assistant manager] is here for staff to chat to." We saw both the branch manager and assistant were readily available to support people and staff. We noted a strong sense of comradery between care staff and management. Staff members we spoke to told us they were happy working at Haddington Vale. One staff member said, "I feel supported by the manager, I can go to them for anything." Another staff member said, "I enjoy working here." The assistant manager said, "We are about the service so if needed we can lend a hand." Care staff told us they felt well supported by the manager and she and the assistant manager were approachable.

Staff had structured opportunities to share information and give their views about people's care. The branch manager told us staff meetings were held regularly but the service had only begun recording the outcomes. In September's meeting we saw a number of areas were discussed including clients, health and safety, training and care plans.

The service had recently gathered the views of staff via their staff survey. We saw the question, "Are you informed about the needs, choices and preferences of the people you provide care to?" 86% said yes.

Following the survey the service developed actions to be completed including for staff to review care plans.

People were regularly asked to give feedback on the service they received. We saw the service issued monitoring and quality assurance questionnaires and people's comments were positive.

The registered manager has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not specific and did not focus on the wishes and needs of people.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not carry out MCA assessments and 'best interests' decisions for people who may have lacked capacity to make decisions for themselves.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to identify, assess and manage risks to the health and safety of service users of using the service. The provider did not have adequate systems in place to ensure the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems and processes to make sure they assess and monitor their service.