Horizon Homecare (Southern) Ltd

Horizon Home Care - 386a Ashley Road

Inspection report

386a Ashley Road
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Date of inspection visit:
19 April 2018
26 April 2018
01 June 2018

Date of publication:
25 June 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

Horizon Home Care - 386a Ashley Road is a domiciliary care service. It provides personal care to adults living in their own homes in the Poole, Bournemouth and East Dorset area. This includes a team of twilight staff, who provide night visits across the area. There were around 240 people receiving personal care at the start of the inspection. Not everyone using the service receives regulated activity; CQC only inspects the service being received by people provided with 'personal care', help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

At our last inspection we rated the service good overall, but requires improvement in Responsive as there was a breach in the legal requirements relating to person-centred care.

At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. The service met all relevant fundamental standards. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

As required under the conditions of its registration, the service had a registered manager, who was also the owner of the company that owns it. 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.

There were systems operating to help protect people against abuse and avoidable harm. Risks were identified and managed so that people were protected from harm. Medicines were managed and administered safely. Staff followed infection prevention and control procedures.

There were systems in place for responding to emergencies, including an out-of-hours on call service.

Staff were recruited safely, following checks that staff were of good character and suitable for their role. There were sufficient appropriately trained and skilled staff to provide people's care. Staff did not always have sufficient travel time allocated between calls that were more than a short walk apart. However, no-one told us they did not receive the care they needed or felt rushed as a result. Action was under way to address this.

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.

People's physical, mental health and social needs were assessed and provided for holistically. Care plans were comprehensive and were kept up to date. The service liaised with other organisations to ensure people received the care they needed and that they had support to manage their health. People were supported to

maintain a balanced diet and to drink enough, where this formed part of their care package.

The service provided care packages for people at the end of life. They worked as part of a team with people's community healthcare professionals and other agencies to ensure people received the care they needed.

Staff treated people with kindness and compassion and promoted their independence. People spoke highly of their regular care workers, who they felt understood them well and attended to how they liked things to be done.

Some people said they had experienced different workers and calls that were not at their preferred time. The service was aware there had been issues and was taking action to address these, including the allocation of workers to postcode districts and the maintenance of a 'waiting list' for calls at preferred times.

Complaints were investigated promptly and outcomes recorded.

The culture of the service was open, transparent and person centred. There was a willingness to speak with people and their relatives when things went wrong, and to bring about any improvements that were necessary.

The registered manager, who also owned the provider company, adopted a hands-on approach.
Staff knew how to raise concerns and felt these would be taken seriously. Staff meetings were held regularly, and staff were also supported through supervision.

Governance systems were in place to ensure the service remained safe, effective, caring and responsive to people's needs. However, people did not all recall anyone from the office visiting or telephoning them to ask if they were happy with the service.

We recommend the service reviews and maximises the opportunities it has to obtain feedback from people.

The service worked in partnership with other agencies to ensure it remained sustainable

Further information is in the detailed findings below.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service had improved to Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Horizon Home Care - 386a Ashley Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 19 and 26 April 2018, with telephone calls to a sample of people who use the service during the week commencing 8 May 2018. We announced the inspection on 13 April 2018. We gave the service this short notice so that they could update their list of people who would be willing for us to visit or telephone them.

The inspection was undertaken by an adult social care inspector, an assistant 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.

Inspection site visit activity started on 19 April 2018 and ended on 1 June 2018. It included shadowing care staff while they visited people, although we did not observe intimate care. We spoke with six people and two relatives in their homes, six care workers, six office-based staff, the deputy manager and the registered manager. We also telephoned 12 people who received a service and seven relatives. We visited the office location on 19 and 26 April 2018 and 1 June 2018 to see the manager and office staff; and to review care records and policies and procedures. We reviewed five people's care records, including assessments, care plans, care records and medicines administration records. We also reviewed four staff files, staff schedules, audits and quality assurance records.

Before the inspection we reviewed the information we held about the service. This included incidents they had notified us about. We also obtained feedback from two local authority contract monitoring teams. A Provider Information Return had not been requested within the year prior to the inspection. A Provider

Information Return 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.

Good

Is the service safe?

Our findings

There were systems operating to help protect people against abuse and avoidable harm. People were provided with information about staying safe and how to report any concerns. Staff had training in safeguarding. They had a good understanding of the safeguarding policy to protect people from harm and abuse and were able to explain how they would raise any safeguarding concerns. The service had worked in cooperation with local authority safeguarding teams to investigate safeguarding concerns and had acted promptly to reduce risks to people.

Risks were identified and managed so that people were protected from harm. Risk assessments were undertaken at the start of a package of care and covered areas including falls, vulnerability to pressure sores, moving and handling, and the person's home environment. These were reviewed at least annually and as people's needs changed. A relative commented, "When we started with the agency, the person that came to visit us at home advised us about moving some of the furniture and taking up a couple of loose rugs so that there were less things for Mum to trip over."

There were systems in place for responding to emergencies. During office hours, people who used the service and staff could telephone the office. For example, a care worker could ring in if they were unable to work because they had become unwell. Office-based staff would provide support such as arranging replacement staff or covering the call themselves. Outside office hours there was an on call telephone contact system. People and all but one member of staff said they had no difficulty contacting the on call service, and that calls were promptly returned.

There were sufficient appropriately trained and skilled staff to provide people's care. The service continued to recruit staff to ensure this was the case. Most care workers were allocated to 'runs', or series of calls, in a postcode district, to reduce travelling time. This helped the rota co-ordinators see whether the service had the capacity to take on new care packages in particular areas. Staff did not always have sufficient travel time allocated between calls that were more than a short walk apart and we saw one staff rota where a next call was set to start shortly before the previous one finished. However, no-one told us they did not receive the care they needed or felt rushed as a result. The provider and rota co-ordinators recognised there had been an issue with travel time and the accuracy of rotas. An additional co-ordinator was being sought to help improve accuracy. The service was also about to introduce a new computer system that would enable better monitoring of call lengths and late visits.

Staff were recruited safely, following checks that staff were of good character and suitable for their role. These included references from previous employment, obtaining a full employment history with a satisfactory explanation of any gaps in employment, and checks with the Disclosure and Barring Service.

Medicines were managed and administered safely. People who received assistance with medicines told us they had their medicines on time and as required, other than one person who commented, "The timings of my calls can vary quite a bit so there can be a big gap between doses and other days they're almost on top of each other." Care staff were trained how to administer medicines and senior staff checked their

competence in handling medicines at least annually to ensure they continued to administer medicines safely. Assessments and care plans set out the extent to which care workers were to support people to take their medicines. Medicines administration records (MAR) were detailed and contained few, if any, unexplained gaps. MAR were returned to the office at the end of each month for audit by senior care workers. Where any issues were found, these were recorded and followed up with the care worker concerned.

People were protected from the spread of infection. People who used the service confirmed that staff wore protective equipment, such as disposable gloves and aprons, and always cleaned their hands. Comments included: "I never have to remind the carers about wearing disposable gloves and putting their aprons on and they are very good at washing their hands and changing gloves between tasks. I've never concerned myself with the hygiene aspect of their work at all" and "I haven't had to remind my carers once because they seem to just do it automatically." Staff all received infection prevention and control training. Almost all staff had had food hygiene training within the past three years. Staff understood their responsibilities in relation to infection prevention and control. Senior care staff checked that care workers were following the infection control policy and procedures when shadowing their visits. The care workers we shadowed all had an ample supply of personal protective equipment.

There was a culture of willingness to learn lessons when things went wrong. Following complaints or safeguarding investigations, the service had arranged meetings for staff to discuss and come up with ways to improve. For example, people using the service complained they were not receiving their rota in time; this caused them to feel anxious as they not know who was coming and at what time. To help overcome this, the registered manager invested in a franking machine to help ensure people would get their rotas on time.

Good

Is the service effective?

Our findings

People's physical, mental health and social needs were assessed holistically. These were used to develop care plans that reflected how staff would meet their particular needs. Care plans were reviewed annually, or when people's needs changed. A person using the service commented, "Yes I do have a care plan, it's in my folder where the carers write their notes. I can't remember when somebody came to go through the care plan with me last but I do know that nothing really has changed with my health or the help that I need from the carers." Assessments and care plans covered activities of daily living including washing and dressing, sleeping, eating and drinking, mobility, communication, health and medical care, medication, mental health, social needs and relationships, and money and finance. Protected characteristics under the Equality Act, such as sexuality and ethnicity, were recorded if people wished them to be. Staff had training in equality and diversity, although not specifically in equality for lesbian, gay, bisexual and trans (LGBT) people. The registered manager was interested in recent media coverage about care at home for LGBT people and said she hoped to use this in future training.

The service worked with other organisations to ensure people received the care they needed and that they had support to manage their health. No-one we spoke with said they had needed the service to get medical attention for them. However, we observed a care worker contact someone's housing provider when there was a problem with their hot water. People's care records contained details of GPs and other health professionals involved in their care. The service had introduced new procedures when dealing with falls. Senior staff had received training from the ambulance service about responding appropriately to falls where people had not been injured. As a result, the service had updated its moving and handling and falls policies. It had acquired the right equipment for senior staff to help people off the floor after an non-injured fall.

Staff had the skills and knowledge to deliver effective care and support. They received training in order to carry out their jobs, including but not limited to: manual handling, equality and diversity, fire safety, and safeguarding. Staff were given different types of training to suit their learning styles, including face to face training and e-learning. The service used in-house trainers with 'train the trainer' qualifications and also arranged training from outside the organisation. Staff employed for the first time in care were completing the Care Certificate. The Care Certificate is a nationally recognised set of standards expected of staff working in health and social care. A member of staff told us the registered manager was approachable and open to funding training staff would like to attend to help them develop further in their careers. When accepting new care packages for people with specific care needs, the service arranged additional training to support care staff to meet those people's needs.

Staff confirmed they were supported through regular supervision meetings with a more senior member of staff, to discuss their work, any concerns they may have, and opportunities for development. Staff files contained records of supervision meetings at least three monthly.

People were supported to maintain a balanced diet and to drink enough, where this formed part of their care package. They were happy with the support they received in this regard, and confirmed that staff provided food of their choice. Comments included: "My carers make all of my meals for me and my family

buy me frozen ready meals these days so my carers will see what I've got and let me know, so I can choose what I fancy to eat", "I'm not a very big eater these days, but my carers are good and will make me a sandwich for my lunch depending on what I fancy and they usually try and tempt me with a cake or some biscuits for the afternoon while I'm by myself", "Whilst I can get myself a cold drink, I'm not very safe to pour hot drinks these days so my carers will always put the kettle on as soon as they come through the front door and make me a nice cup of tea and then they will make another cup for me before they leave", and "Mum is very good at drinking these days so we rely on her carers to encourage her as much as they can while they're there and they always ensure she has at least one hot drink on each of the four visits that they make to her during the day and then they will leave a cold drink on her table next to her chair to try and encourage her to drink that when they're not there with her."

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 the least restrictive possible.

People's rights were protected because the staff acted in accordance with the MCA. People told us staff checked they were happy to receive care before they provided assistance. For example, one person said, "My carers never force me to do anything that I don't feel like doing and they will always ask me if I want to have a shower or just a strip wash or some mornings I don't fancy anything at all." People's consent was sought to confirm their agreement with their care plans, if they were able to give this. If there were concerns that someone might lack the mental capacity to give consent, this was assessed. Where they were found to lack capacity, a best interests decision had been recorded so the person's needs were met in the least restrictive way possible.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People were positive about the manner of their care workers and we observed that staff interacted with people in a respectful and caring way. When asked about the approach of their care worker, one person told us, "[Name of care worker] is fantastic. The night staff are nice as well." Another person commented that their care workers were "not intrusive or anything". Other comments included: "My carers are lovely and they just get on and do everything and if I have anything extra that I need help with I will always ask them because they will always make time to help me if they can" and "Yes, it's one of the highlights of my day when my carer arrives because I know I can have a conversation with them and we talk about everything and nothing, which is what I like."

People spoke highly of their regular care workers, who they felt understood them well and attended to how they liked things to be done. Comments included: "Because my carers have been coming to me for a while, they know me and they know my likes and dislikes, so I never have to tell them how I like things to be done and they just get on and do it these days, which makes life so much easier for me", "My regular carers are very good and always know what needs doing and will sometimes even say to me that they've noticed I've got some washing piling up and that can they help me by putting it in the washing machine" and "My carers aren't really supposed to be here to tidy up, but they know how I don't like living in a mess and when they have time, they will do those little jobs that I really can't do any more." Throughout our observations, people knew staff well, and were able to chat with them easily. The staff readily understood their wishes.

Some people said they had experienced different workers and calls that were not at their preferred time. Comments included: "My regular carers seem to be able to fit in to the times that suit me. However, at weekends, or when my regular carers are on holiday or ill, there can be huge differences in the timings of my calls", "When I first joined the agency, I was asked what time I wanted a carer, but for the majority of time, the carers appear anything up to 60 or even 90 minutes after the time I had originally said I would like them to come" and "I get sent a list usually on a Friday which tells me who will be coming for the following week and roughly what time they should be with me. There will sometimes be new names on that list of carers that I haven't met before and I don't usually get the opportunity to meet them until they actually come through the door when they are due to be here for the first time." We followed this up with the registered manager and coordinators.

The registered manager told us they were strict about the usual practice being for staff being introduced to someone's care to have shadow shifts with a worker who knew the person. However, they acknowledged that there had been some occasions where this had not happened. The allocation of care workers to particular postcodes sought to improve continuity of care and reduce travel time. However, floating care workers or office-based care staff stepped in to cover absence. When new packages were taken on, commissioning parties did not always provide information about timings that was consistent with people's preferred call times. This was exacerbated by the introduction of a new contract at the end of 2017. The coordinators therefore maintained a waiting list of desired times, offering these as they became available. One person's comment illustrated this: "I did originally ask for a male carer if at all possible but

unfortunately they didn't have anyone available at the time when I started having care provided. However, recently, they have changed my carers and I see [male care worker] who comes to me and covers all the week. He is really nice and we can have a good old chat and I look forward to seeing him every day."

People told us staff promoted their independence. Comments included: "My carers are particularly patient because they will let me try and do the little jobs that I can do for myself and they will only step into take over when they can see that I'm really struggling. I like to just still try and do as much as I can for myself even though I'm conscious that this is getting less and less as the time goes on" and "It's really important to me that I stay independent for as long as I can and my carers help me to do that."

People were supported to express their views and be involved in decisions about their or, where appropriate, their family member's care. A relative told us, "My mother-in-law has dementia and we are very grateful to her carers because we don't live close by, so they are our contact so that we know what is happening to her on a day-to-day basis. If the carers are worried at all they will ring either [spouse] or I." Another person and their relative lived together and their interests in relation to certain aspects of their care conflicted; the relative received care from another provider. The service recognised this and was working with health and social care professionals to promote the needs and wishes of the person they were supporting. They had identified the person might benefit from an advocate and were liaising with the person's team to provide this.

Good

Is the service responsive?

Our findings

At our inspection in September 2015, we found a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to person-centred care. People's care needs were not always fully assessed and planned for, particularly in relation to health conditions. Care plans had not always been updated when people's needs changed. The provider subsequently sent us an action plan, saying they would meet Regulation 9 by the end of January 2016.

At this inspection, we found the provider had taken the necessary actions and met the legal requirements relating to person-centred care. Care plans were up to date and fully reflected people's individual physical, mental and social needs. They contained clear information about people's health conditions, such as Parkinson's disease and diabetes, and signs that would indicate a flare up that required action from staff. They clearly set out what people were able to do for themselves, such as washing particular parts of their body.

The service met the Accessible Information Standard. The Accessible Information Standard requires that health and social care providers ensure people with a disability, impairment or sensory loss can easily read or understand and get support so that communication is effective. Assessments and care plans flagged up sensory loss or impaired communication and the way in which staff should support people with this. People whose care we reviewed received the support they needed. For example, we observed a care worker assist someone with a visual impairment in their kitchen. The worker knew the person well, recognised what they could do independently and provided the support that was needed.

The service provided care packages for people at the end of life. They worked as part of a team with people's community healthcare professionals and other agencies to ensure people received the care they needed. The service had received compliments received from relatives thanking staff for being kind and respectful, and for giving care they were very pleased with. The majority of care staff had received training in palliative and end of life care.

Complaints were investigated promptly and outcomes recorded. Lessons learnt meetings were held to identify how the service might be improved. There were many thank you notes and compliments from relatives and friends for the service. One of these stated, "It was rocky at times but you never failed to impress me when you jumped the gun problem solving and came up with revolutionary ideas. Please don't ever change."

Good

Is the service well-led?

Our findings

The culture of the service was open, transparent and person centred. People and relatives told us they could readily contact the office. Comments included: "I always call the office number if I need to speak to somebody and they are very good at picking up the phone, at least they have been whenever I've needed to talk to someone" and "I usually call the office when I want to rearrange a visit to [relative] and I've always found them to be very helpful." Many staff had worked at the service for some years. The staff we spoke with were broadly happy in their work, saying things such as, "I enjoy it. I wouldn't change my job." However, some expressed reservations about rotas and lack of travel time, although the management team were already taking action to address this.

There was a willingness to speak with people and their relatives when things went wrong, and to bring about any improvements that were necessary. Complaints and incidents were investigated robustly, as were issues arising from surveys and that people expressed during the inspection and wished us to pass on to the management. When required to do so, such as if there was a significant injury or a safeguarding concern, the service had notified CQC as it is legally required to do.

The registered manager, who also owned the provider company, adopted a hands-on approach. They worked closely with the management team and staff, including providing care on occasions. Staff told us, "[Registered manager] knows her staff inside out" and "I find [registered manager] approachable." They gave examples of how the registered manager had introduced improvements they had suggested, such as running Dementia Friends information sessions (this is a national scheme aimed at helping people understand what it is like to live with dementia). A member of staff said, "I love working here, I love being able to think outside the box to improve things."

The registered manager and management team had an open door policy to help staff feel able to raise any concerns they may have. Staff knew how to raise concerns and felt these would be taken seriously. Staff had training about whistleblowing and during the inspection, information about how to blow the whistle was displayed around the offices. Staff meetings were held at least monthly. Staff met in their locality team to discuss the best ways of caring for people, agree outcomes, and discuss any additional support needed and ways in which the service could be improved. There was also communication with staff through newsletters, emails and through social media.

Governance systems were in place to ensure the service remained safe, effective, caring and responsive to people's needs. There were annual surveys of people and staff. There were checks and audits of various aspects of the service, such as medicines records, care records and accidents and incidents. Senior care workers completed spot checks on care workers, including medicines and infection control competency checks, to ensure they continued follow the procedures correctly. Action was being taken to improve audits, such as keeping all accident and incident records in one centralised folder so this was easier to track for any trends.

People did not all recall anyone from the office visiting or telephoning them to ask if they were happy with

the service. They reported that someone from the office called round every couple of months also to take away the old records and replace them with fresh ones. However, they did not ask people about their satisfaction with the service or whether anything needed looking at in the care plan.

We recommend the service reviews and maximises the opportunities it has to obtain feedback from people.

The service worked in partnership with other agencies to ensure it remained sustainable. At the end of 2017 had become part of the local commissioning framework. The registered manager and senior management team attended local and national meetings for care providers to keep abreast of legislation and developments in good practice. Training for managers and senior staff had been sourced from a nationally respected organisation, in order to provide key staff with a sound working knowledge of the Mental Capacity Act 2005.