Manorcourt Care (Norfolk) Limited

Manorcourt Homecare

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 30 September 2016. After that inspection we received concerns in relation to risks associated with aspiration and dysphasia. Dysphasia is the medical term for swallowing difficulties or an impairment in swallowing. As a result we undertook a focused inspection on 07 and 08 December 2017 to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Manorcourt homecare on our website at www.cqc.org.uk.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and specialist housing. It currently provides a service to 149 older adults.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of inspection we found that people's written information did not always adequately record and reflect risks to people or provide sufficient detail for staff on how to manage those risks with regard to Dysphasia. However, guidance was available within the providers Management of Dysphagia Policy. We made a recommendation that appropriate training should be provided if anyone using the service is assessed with dysphasia.

Whilst risks to people were alleviated by staff knowledge and experience, the potential for risk existed. Therefore we made a recommendation that the service review the system and process for recording, managing and sharing information on risk to ensure the safe and effective management of Dysphagia as described by the providers own policy.

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.

Information related to risk of dysphasia and aspiration was available to staff.

We recommended that the systems and processes for recording information on risk required reviewing.

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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 checked 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 was prompted in part by notification by the provider of an incident following which a person using the service died. The information shared with CQC about the incident indicated potential concerns about the management of risk of Choking. - This inspection examined those risks.

We previously carried out an unannounced comprehensive inspection in September 2016. At that time Manorcourt homecare was awarded a rating of 'Good' in all five key questions.

In response to information of concern we had received regarding the safe care and treatment of people, we carried out an unannounced focused inspection of Manorcourt homecare under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We inspected the service against one of the five questions we ask about services: is the service safe?

The inspection was undertaken by two inspectors. Before our inspection we reviewed all the information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events, which the provider is required to send us by law. We also reviewed information received from relatives of people who used the service.

During the inspection we spoke with the registered manager, a scheme manager and a regional manager. We reviewed various documents including three people's care records and other documents central to people's health and well-being.

Good

Is the service safe?

Our findings

This focused inspection was carried out in response to concerns raised regarding aspiration and dysphasia. Dysphasia is the medical term for swallowing difficulties or an impairment in swallowing. This condition can result in an increased risk of aspirating (where food or fluid enters the lungs) or choking.

The registered manager told us that at present there was no-one receiving a service that had risks associated with aspiration or choking. We looked at the care records of one person identified at risk of dysphasia although in this case the person was no longer having foods or fluids orally, but had a Percutaneous endoscopic gastrostomy (PEG). This is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate (for example, because of dysphagia. We found that there was no specific risk assessment in place for dysphasia. However, in the care plan we reviewed we saw that guidance on how to manage the persons PEG had been recorded.

Whilst written care records did not always adequately monitor and reflect the risks of dysphasia to people or provide detailed guidance for staff on how to manage those risks. The registered manager sent us the providers policy on the management of dysphagia and their nutrition and hydration Policy from August 2017. These documents had been shared with staff working at the service. We also saw evidence that people were referred to Speech and Language Therapist (SALT) if a risk was identified. The policy stated that a risk assessment will be conducted for individuals identified as at risk of choking and a monthly evaluation will be used.

We spoke to both the registered manager and scheme manager who had knowledge and experience of people who used the service and access to guidance through the policies mentioned above. However, the potential for risk existed should new or agency staff be on duty who may not be as familiar or knowledgeable with people's individual needs or not have access to the guidance within the policy.

Therefore we recommend that the service review the current system of recording and sharing information on risk and ensure specific risk assessments and written guidance for staff is accessible within the individual's care plan to ensure the safe management of dysphagia and aspiration.

Whilst we accept that the service did not have anyone currently at risk of choking or aspiration we noted that the policy included that training and guidance would be provided in relation to supporting individuals with food and nutrition requirements including assistance at meal times. The registered manager had sent us the training matrix and we noted that training had been provided for food hygiene and the registered manager told us the management of dysphasia and aspiration was briefly covered within this training course. We recommend that the provider identifies an appropriate training course to support staff providing care for anyone assessed with dysphasia.