Suffolk County Council

Home First Haverhill

Inspection report

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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

This inspection took place on the 21 and 26 October 2016 and was announced.

Haverhill Home First is a domiciliary care service who provide short-term re-enablement packages to people in their own homes. At the time of our inspection there were 27 people using the service. The service shares a registered manager and additional resources with two other Home First services in the area.

There was a registered manager in post although the service is not required to have one and the day-to-day management was handled by two team leaders. 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.

The service took a robust and thorough approach to keeping people safe by completing a comprehensive risk assessment prior to commencing a package of care. Assessments of people's mobility, environment and medicines were carried out to identify risks and implement suitable control measures for staff to mitigate them. The service created a person-centred plan based on outcomes and goals for re-enablement, which provided a consistent method for staff to work to when delivering care. Rotas and the allocation of visits were managed effectively to enable staff to get to people on time and spend the correct amount of time providing their care and support on each visit. While there had been difficulty recruiting to the service which had resulted in some staffing shortages, the service utilised resources creatively to ensure that people always received care and were not placed at risk.

The service worked closely with other professionals as part of people's re-enablement and were able to contribute effectively towards supporting people with their healthcare needs. If people required assistance with taking their medicines then they received this support from trained and competent staff who managed their medicines safely.

Staff received a wide range of training to undertake their duties effectively and were able to demonstrate how this training was put into practice. The staff team was experienced and skilled and demonstrated a strong commitment to providing positive outcomes for people. They were provided with regular supervision and performance reviews which encouraged them to share views and reflect upon their practice. They understood their roles and responsibilities and were knowledgeable about the ways in which people gave consent and how the Mental Capacity Act (2005) was applied in practice. The staff we spoke with demonstrated a caring attitude and understood how to treat people with dignity and respect. Staff meetings were held fortnightly and provided an opportunity for the team to meet and discuss issues affecting the service. New staff received a full induction into the service, and robust recruitment procedures were in place to ensure they had the skills and experience necessary for the role.

There were robust processes in place for monitoring quality and identifying improvements that needed to

be made across the service. The management, leadership and culture within the service was empowering, transparent and consistent, and we found the overall governance and organisation of the systems used in the delivery of people's care to be well managed and implemented at all levels.

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.

Risk assessments detailed ways in which risks to people could be minimised to keep them safe from harm.

Staff were recruited safely to work in the service.

People's medicines were administered safely by trained and competent staff.

Is the service effective?

Good

The service was effective.

Staff received the correct training and supervision to enable them to fulfil their roles effectively.

People gave consent to their care and staff had knowledge and understanding of the Mental Capacity Act 2005 and how it applied in practice.

People's healthcare and dietary needs were assessed and met where appropriate.

Is the service caring?

Good

The service was very caring.

Staff were kind and compassionate and understood people's needs and preferences.

People were treated with dignity and respect and staff went the 'extra mile' to provide person-centred care.

Records were kept securely and confidentially was maintained.

Is the service responsive?

Good

The service was responsive.

Care plans contained an appropriate level of detail to enable

staff to offer effective support, and were regularly reviewed with involvement from the person and their relatives.

People were supported to achieve positive outcomes.

There was a complaints system in place to handle and resolve people's complaints promptly.

Is the service well-led?

Good

The service was well-led.

People and staff were positive about the manager of the service.

There were robust quality assurance systems in place which identified improvements and changes that needed to be made.

Team meetings were held regularly to give staff the chance to discuss issues affecting the service.

Home First Haverhill

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 21 and 26 October 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that somebody would be available at their registered office. The inspection was carried out by one 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.

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 reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with nine people who used the service, three members of staff, the registered manager and one relative. We looked at three care plans which included risk assessments, guidelines, healthcare information and records relating to medicines. We looked at two staff files including recruitment information, training and induction records, and details of when staff were supervised. We also looked at quality audits, satisfaction surveys, minutes of meetings and complaints received by the service. We also reviewed information on how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

People using the service and their relatives told us that they generally felt safe when receiving care and support from the service. One person said. "The [staff] have been wonderful, and very safe with me." A relative told us, "It's very safe and [relative] has had no accidents with them."

When we asked people if staff arrived within the time frame specified and stayed for the correct amount of time, we received a variety of responses. One person said, "Most staff call on time and are lovely with me. They are really nice and have helped me since I came out of hospital and realised I needed some help." Another person said, "I've no complaints at all and they are nice people who are reliable and on time, it's very safe." However one person did raise some concerns with inconsistency of visit times and told us, "They call at silly times, it should be ideally around [time] but it can be two hours each way at times. When I complained to the supervisor, they just said that this was due to them needing to use two staff to help me, but when I said one staff was ok, this made things even worse. They called the other day at nearly 2pm for the lunch visit then at 3:15pm for my tea."

We spoke with the registered manager about these visit times and she explained that due to the nature of the service they were only able to provide people with specific windows of time where they would deliver care. This was because they were providing re-enablement care to people at short notice and had to manage the deployment of staff in a way that would have made it challenging to promise specific times to people. We saw that this was clearly stipulated as part of their initial contract of care with the reasons explained to each person. However it was acknowledged that this was too short a gap between calls and that the service would always endeavour to send staff at reasonable times to meet people's needs.

We asked staff if they were able to get to people on time and stay for the correct amount of time. A team leader said, "We work within a window of time for most people and we'll provide care to them between those hours, which means we're able to deliver on what we're promising them. Of course if somebody does have a time specific medication or an appointment, then we'll try and have a much shorter 15 minute window." If visits were shortened or missed then the reasons why were clearly recorded as part of the on-going monitoring introduced by a new electronic system. For example we noted that a person who received significant help from their spouse had cancelled or shortened a number of visits. These were listed in the care plan along with the relevant correspondence and reasons, which meant that the service were able to account for any discrepancies in visit records.

When we asked staff about staffing levels, one team leader said, "There are problems with staffing and recruitment. If somebody's gone off sick we will have to call the family, but it's very rare and we'll use all the resources available to us. We do use staffing resources from the other teams in the area and we'll help them out too if we can." When we looked at how staff were allocated on the service rota, we found that they were able to fulfil people's visits within the specified times and that visits were not being missed or shortened unless a reason was clearly given. Despite the recruitment challenges faced by the service, there were enough staff deployed to keep people safe.

Prior to commencing a care package, a risk assessment was completed by a trained risk assessor who visited the person at their home. Each risk assessment considered the safety of the environment, equipment used, infection control and the person's mobility. Control measures were then recommended based upon the person's level of support needs, which may have included assistive technology or equipment supplied by other healthcare professionals. A professional involved with the service told us, "When carrying out an assessment in the customers home, I have found that the risk assessments are in place and up-to-date."

Because the service was often the first point of contact for people after being discharged from hospital, risk assessments had to be detailed and thorough enough to capture any immediate issues that could have required further intervention or referrals to other supporting professionals. For example we saw that for one person, it had been identified they could be at increased risk of falling without a perching stool and a raised bed. This equipment was then requested for subsequent visits. For people who required assistance with mobilising, the staff were provided with full instructions on how to use lifting and hoisting equipment, and these were written in sufficient detail to allow them to follow a consistent approach each time. To support the safety of staff working in the community, they were issued with equipment such as head torches, snow shoes, first aid kits and personal alarms.

The staff we spoke with were able to describe some of the ways in which they kept people safe. One member of staff said, "The main thing when it comes to safety is the training and we make sure that the staff know what they're doing when using equipment or visiting people's homes. We will usually do a risk assessment straight away. We get constant feedback from staff and we'll check the paperwork, observe and make changes as needed. If there are concerns then we'll get in touch with the social worker and talk about the discharge and their on-going care."

The provider followed a robust recruitment process to employ staff who had skills and experience for their roles. Staff were asked to completed a detailed application form which tested their existing knowledge in areas such as safeguarding and promoting independence. Once assessed as being suitable, prospective staff were then asked to provide two employment references and complete a DBS (Disclosure and Barring Service) check. DBS is a way of employers checking whether employees have any prior convictions to allow them to make safer recruitment decisions. We looked at the files for two members of staff and saw that each of them had the relevant checks completed prior to commencing their employment.

The registered manager told us that the service put people's safety first at all times. She described to us an innovative scheme whereby they used a new electronic system to receive information from the police about local crimes and concerns that the office staff then sent out as alerts to people and staff. This ensured that they were aware of any local risks or dangers and that they took appropriate action to keep safe. This demonstrated a strong commitment to protecting people's safety.

Any incidents that occurred within the service were recorded in detail alongside remedial actions taken to reduce the risk of recurrence. The lessons learned from each incident were recorded in detail to demonstrate the response from the service to protect people and staff. The service had accounted for various emergency situations that might have caused incidents or meant that staff were unable to attend to people's visits. We saw completed incident reports which were also translated over into the electronic system so that care staff were aware of any resultant changes to the person's needs or care plan.

If people required support with taking their medicines, then this was indicated in their care plan with a list of the medicines they took and the level of assistance required. The people we spoke with told us they received their medicines on time. Staff received training to understand the correct procedures in the administration of medicines and were subject to a competency assessment prior to carrying out this element of their role.

One of the team leaders explained the process for managing medicines. They said, "The first carers would go in and look at the medicines they have bought back from the hospital or keep in their homes. We'll cross reference patient discharge summaries and work out exactly what they need and the level of support required. We have a system where we check medicine administration records (MAR) charts and we'll put this in the action book to bring up with staff. We have medication quizzes to test staff's knowledge too so that we're refreshing knowledge in this area."

Good

Is the service effective?

Our findings

We received a variety of responses when we asked people if they felt the staff were trained to be able to deliver effective care. One person said, "The care staff have been very good, I can see no faults in them." A relative told us, "They [staff] seem well trained and they brought another new person to learn the procedures, and they have been good too." However one person did tell us, "I don't rate the staff they have sent me and I would not recommend them, they are not good enough." We discussed the issues raised by this person with the management team and they were able to evidence how they had attempted to address the person's concerns, including changing the staff who supported them and the type of care they were providing to attempt to meet their needs. One other person told us that because of frequent changes in staff, they were not always sure who would be providing their care. They said, "I feel safe with their staff and I've not had any accidents with them, but I'm not very much at ease with some of the staff as others." When we asked whether they had addressed this with the management team they told us, "Most of their staff are really good, when I told the supervisor they said 'it's not good enough.' So they did straight away accept this was not good."

The staff we spoke with were positive about the training they received and how it had improved their practice. One of the team leaders said, "We're trained to Level 3 of the Qualifications and Credit Framework (QCF) and I'm a trained risk assessor. I've also been trained to deliver manual handling and observe medication competency. Basic life support training is given to all of us including the carers. I've also done confidentiality, data protection, and quality recording which reinforced the importance of legality when making concise and clear records. We also took a college medication course and we went for an induction and completed a lot of work online. We refresh regularly with a pharmacist. The overall quality of training is very, very good."

When staff began their employment with the service they were given a comprehensive induction which included a chance to read through policies and procedures, learn to use the equipment operated by the service and begin working towards completing the care certificate training. The first day of induction was completed at the office and they then worked alongside an experienced member of staff. Once they had completed their induction they were then observed by Team Leaders while providing care in people's homes. They were rated in areas such as punctuality, working to the care plan, and health and safety. We saw that where issues had been identified, remedial action had been taken to suggest improvements to practice. Staff were provided with opportunities to complete QCF qualifications Level 2 and 3 in health and social care.

Staff told us they received regular supervision and performance review from their manager. One member of staff said, "We have supervisions and performance reviews every six weeks, we'll talk about the visits we're making and how we're communicating important messages across the team." One of the team leaders told us, "Usually every six to eight weeks we'll have a supervision and they're very helpful if you've got a lot of things that you need to unload. We've had supervision training and we supervise our own staff every six to eight weeks too. Of course if they want to come and discuss something with us they can, any time."

Staff received training to understand the Mental Capacity Act (2005). 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. One of the team leaders explained how they approached issues relating to capacity. They told us, "We'll give them the benefit of the doubt and assume they have capacity unless proven otherwise. If we're concerned about how the customer is presenting, then we'll speak to their allocated worker. We assess again if there were any issues around capacity because people's capacity can change quickly because they're often in recovery. Sometimes we're in a position where a family wants us to make decisions for people, but we always have to respect their choices and their wishes, so we're very careful with how we manage that."

People were asked to provide their consent when their care package began, and we saw in the care plans we looked at that people had signed to indicate consent during their initial assessment. If they required support in specific areas such as administration of medicines, then they were asked to sign to indicate that they were happy to receive assistance with this.

The service was able to demonstrate how they worked with community based professionals including occupational therapists, nurses and physiotherapists to support people's on-going rehabilitation. People's healthcare conditions were listed in their care plans along with details of the healthcare professionals involved in their care and how the service could work alongside them to support people's on-going care. Staff were positive about the way they worked with community-based professionals to support people's care One member of staff said, "We refer to the community care team if people need additional support and that's working very well; if we need a physio or an occupational therapist then we get one and they work with the team. If we're concerned we'll go and speak to them and they appreciate us giving them that level of feedback."

If people had specific dietary needs, allergies or food preferences, then these were listed in their care plan along with the support they required from staff. One of the team leaders told us, "We'll usually write down the kind of food they require and the level of support they need or any dietary needs like diabetes or soft diets. We'll put down allergies too."

Good

Is the service caring?

Our findings

The people we spoke with told us that the staff who provided their care and support were kind, considerate and caring, although we received some mixed views on the quality of some staff. One person said, "They've been absolutely brilliant. The carers who come in have been absolutely marvellous, I would definitely recommend them." A relative told us, "They have been really good, another [provider] are taking over from next week and they've told us about it and came to see us. It's been excellent." However one person told us, "I don't rate the staff they have sent me and I would not recommend them, I don't always feel at ease with them." Another person told us, "I'd still want to recommend them and they are good overall, though some staff perhaps need better supervision."

The staff team were positive and enthusiastic about the care they provided and the relationships they had developed with people. One member of staff said, "I love the team I work with and we support so many nice people. The best thing about working here is that we don't have to rush people and we make people feel close and it's just so rewarding and making a difference for people. Another member of staff said, "I feel proud to be a part of the service and it's the first time I've worn a uniform with pride." One of the team leaders told us that they tried to ensure that the care they provided extended beyond the provision of their initial re-enablement package. They told us, "We keep in touch with people throughout the time we see them, from the initial assessment to the implementation of their care and then reviewing afterwards. We make people aware that they can contact us whenever they like and we want people to stay in touch."

As part of their on-going support, in addition to providing the details of local advocacy services, people were also provided with details of other services who could provide immediate or long-term support. The service asked people if they were aware of their benefits entitlements and personal budgets, the availability of assistive technology, local meal providers and any other service that might have proved useful to them. One of the team leaders told us they felt they had a caring team who always put people's needs first. They said, "I think the carers are all so on-board with the enablement process that they'll be thinking about the person before they begin carrying out the tasks. While we have a more specific way of working now, the staff still have the caring aspect to their character and they'll still help people as much as they can with everything, not just what they're in there to do. If somebody wants a cup of tea and a chat, then we'll always do that if we can."

We saw an example of some positive feedback received from a person which said, "Home First Service has been amazing and without their dedicated care and expertise we would have been lost. Returning home from hospital is not only very emotional but also a little frightening. The carers who were sent to us eased that fear as their brightness and humour radiated through the house four times a day. Amidst laughter and in a very relaxed, comfortable and enjoyable atmosphere, we feel that the goals which we are aiming for will be more easily achieved because of being able to discuss them in a very adult and grown up way." Other compliments included "[Relative] and I are so grateful for the time you spent looking after [them]. We will never forget your kindness and support and will always think of you all with great affection." Another said, "I want to thank all the staff and carers for all your help and kindness. I will miss all your friendliness and care so much."

We were also given an example of when care staff had gone the extra mile to provide care to somebody who had been referred to them over the Christmas period and did not have a fixed address. The staff team worked with the person to find them accommodation, find furniture and fittings and spent time with them over the Christmas period to make sure they had a meal and presents to open. This demonstrated a caring attitude and regard for people's welfare that went the extra mile and resulted in the person being able to settle into new accommodation and begin to rebuild their life positively. We were also told about another example where a member of staff had looked after somebody's dog for them for two weeks while they were in hospital. A person had recently celebrated their 90th birthday and the service provided them with a birthday cake and card.

People told us they were treated with dignity and respect when staff were providing their care and support. One person told us, "They all treated me nicely." One relative said, 'They help [them] with [personal care] and they take the time to do this right, with dignity." We asked the staff about the ways in which they observed people's right to privacy and dignity. One of the staff said, "If there's any way that we can work with people to maintain their dignity and privacy then we will. We'll cover them up, knock on their doors, speak to them in the appropriate way. We do our best to keep their dignity. We put ourselves in their shoes and treat them as they would be treated, or how you would want your mother to be treated."

Good

Is the service responsive?

Our findings

The people we spoke with told us they were involved in the planning of their care and knew they had a care plan in place. One person said, "Someone came twice to check on [the care plan], and yes that it was what I agreed to and what came next. At first they came out four times a day, then down to just the two." Another person said, "The [manager] discussed how much I was able to do to care for myself and adjusted the service accordingly."

We looked at the care plans for four people who used the service, two of whom had received care packages at various times due to repeat admissions to hospital or on-going healthcare needs. We saw that initial assessments had been completed which included information such as the person's social situation, the type of property they lived in, their mobility, dietary needs and a profile of their sensory needs. The staff we spoke with explained how they had been informed of the nature of people's needs and the care they would be providing. One member of staff said, "We have an assessment which we go through and we then work out a care plan based on their assessment, and we'll tell the person what we're going to do."

Referrals to the service usually came from hospitals or the local social work teams. The service would be forwarded an initial assessment with the person's background, needs and objectives which they could then use to develop a more comprehensive assessment and care plan. Because people were transferring between services, the service had to carry out a comprehensive assessment based on initial visits and observations. In cases where discharges might not have been successful, we noted that quick action was taken to share this information in the best interests of the person. For example in one person's care notes we found that they had been discharged after being assessed as medically fit, although they were still presenting with some symptoms which were of concern to the care staff who visited them. The person was therefore re-admitted to hospital for their safety and the service were able to resume their re-enablement support once appropriate.

People's care plans were developed with outcomes such as 'take medication independently' or 'be able to make the bed'. Daily tasks for the staff to undertake with the person were then listed with the level of support required and how staff could eventually assist the person in becoming more independent with each of the tasks.

The staff we spoke with were positive about the outcomes they had supported people to achieve. One team leader said, "We're working with somebody and helping them to walk again, building up their confidence and working with the community team to reduce them down to single calls. We had one person who came out of a long-term hospital placement who had lost most of their daily living skills and we helped them to regain that independence to the point where they no longer required our support. There's so many stories we're proud of." Another member of said told us, "We went to visit one person who could barely walk and was only able to use one room with a commode. Now with our intervention they can get up the steps and they're having a stair-lift fitted to help them to move independently. Now they don't need us anymore, which is what we're always striving for."

A professional involved with the service told us, "I have generally found that Home First are quick to respond to any changes that may need to be made to the service they provide to a customer and that they always have up-to-date information to hand on request."

The provider had a complaints policy in place which detailed how people could make complaints and how they would be handled. People we spoke with told us they were aware of who to complain to if necessary. The service had not received any formal complaints but we saw how minor complaints and concerns were being addressed correctly with people through communication logs and notes made on the electronic call system.

Good

Is the service well-led?

Our findings

Staff were positive about the management of the service although one member of staff did raise concerns that the senior management team was not always visible or responsive. They said, "I do feel my feedback is listened to by my line managers and by the registered manager, but I haven't met our more senior managers within the council, it would be a good gesture for them to come and spend time with us before making decisions which impact on our work. But in terms of immediate management they work really hard and they're really supportive. I'm very valued and appreciated which is a good feeling at work." Another member of staff told us, "My team leader has been brilliant and the registered manager is brilliant too, I can call them at any time."

One of the team leaders explained to us the ways in which they tried to make their staff feel valued and appreciated and how they promoted an open culture within the service. They said, "Our staff and our people are the most important people in the service. The way we support them and the way we talk to them is important, and they know they can approach us with anything. They're always welcome to come in and talk about anything. We'll go out and support them where we can. We treat them as individuals, like we would the people we support."

When we asked them about the support they received from the registered manager they said, "We get every bit of support we need. [Registered manager] is a really good manager and helps us to develop and we'll have any bit of training we want. She's very helpful and approachable and you can just pick up the phone and ask her anything. She's great. She encourages people to aspire to what they want to do, we want our staff to learn as much as possible while they're with us."

We saw a schedule of team meetings which showed that these took place every fortnight. One of the team leaders said, "In every team meeting we'll discuss learning and development .We try and install positive mental attitude in our staff. We'll try and have a meeting every two weeks. We update on our people and we'll share issues among ourselves. I'll send out a message to staff updating them on customers and we'll follow up on visit times."

The service had an efficient system for auditing and identifying any errors, omissions or inconsistencies in recording or reporting. Each month the records for each person were analysed and any discrepancies were incorporated into an 'action book' which presented individual members of staff with a report on any errors made in paperwork or any pertinent issues relating to people's care. One of the team leaders was able to describe how this was useful for addressing on-going issues with staff. They said, "We'll address all the errors with staff in supervision, or we'll contact them immediately if it's something more serious." By showing the staff real working examples of how they could improve practice, we found that this had helped to reduce mistakes or poor recording going forward. It also meant that the service were able to evidence the action they were taking to highlight and take account of any such inconsistencies.

Because of the short-term nature of the re-enablement packages, the service often supported people with choosing alternative care providers once their period of re-enablement had finished. For example we saw

that for one person the various options for on-going care and support had been discussed. The service had worked closely with each person's allocated worker to communicate and provide them with options and alternatives for their long term care needs. We noted that some packages had been held for a much longer term than intended. One of the team leaders said, "We have a duty of care and we won't stop working with people until we know they are fully enabled to live independently or have a suitable alternative care provider in place." A professional involved with the service told us, "Most customers I visit are very pleased with the service that the Home First team provide and are often saddened that they have to change providers. Home First team do however try and make this transition as smooth as possible for the customer by providing the agency that is taking over with up to date information."