Minchinhampton Centre For The Elderly Limited

Horsfall House Homecare

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

Overall summary

The inspection was announced. Forty-eight hours' notice of the inspection was given to ensure that the people we needed to speak with were available. The inspection was undertaken by one inspector.

Horsfall House Homecare is a run by a registered charity and a group of volunteer trustees. The service provides care and support to people living in their own homes within a six kilometre radius of the village of Minchinhampton, Gloucestershire. At the time of the inspection they were supporting 78 people with a service. Some of those people did not receive a personal care service and therefore did not come within the remit of their Care Quality Commission registration. The service currently had 27 care staff.

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 and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

The registered manager, team leader and care coordinator and the staff team were all knowledgeable about safeguarding issues, knew the appropriate actions to take if concerns were raised and who any concerns should be reported to. All staff received safeguarding adults training. Robust recruitment procedures were followed to ensure only suitable staff were employed. The appropriate steps were in place to protect people from being harmed.

People were kept safe because any risks were well managed. Assessment were made of people's homes to ensure they and the care staff were not placed at risk. This included a review of fire safety in the household and a safer handling plan where care staff needed to assist people to move or transfer their position.

The level of support a person needed with their daily medicines was detailed in their care plan where this was appropriate. Staff completed safe medicines administration training before they were able to assist people and their competency to follow safe practice was rechecked regularly.

Staff were well trained and provided with training opportunities to enable them to carry out their job. New staff had an induction training programme to complete within 12 weeks of employment. All other staff had a programme of essential training and refresher training to complete. Staff were expected to complete additional qualifications in health and social care.

Staff understood the principles of the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions. Where people had been assessed as not having the capacity to make a decision or had no verbal skills, best interest decisions had been made involving others who knew the person well.

People were supported to have sufficient food and drink. Where people needed support with meal preparation this was detailed on their care and support plan. People were supported to see their GP and other healthcare professionals as and when they needed to do so.

The staff, care coordinator and team leader had good, kind and friendly working relationships with the people they were looking after. Staff ensured people's privacy and dignity was maintained at all times.

The assessment and care planning processes in place ensured that people received a service that was tailor-made to their particular care and support needs. People were looked after in the way they preferred and were involved in having a say about the service. People were encouraged to express their views and opinions about how things were going and what they would like to happen.

All staff endeavoured to provide a high quality care service that was safe, effective and compassionate. Measures were in place to monitor the quality of the service and action plans were in place where improvements had been identified. Learning took place following any accidents, incidents or complaints to prevent further occurrences.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were protected from being harmed. Staff knew what actions to take if abuse was witnessed, suspected or reported.

Any risks to people were taken account of and plans were in place to reduce or eliminate that risk. Where staff had to move or transfer people from one place to another they had safer handling plans to follow and were trained to use the equipment.

The recruitment of new staff followed robust procedures and ensured only suitable staff were employed.

Medicines were managed safely and the level of support a person needed formed part of their care plan.

Good

Is the service effective?
The service was effective.

People were looked after by staff who had been well trained and had the required knowledge and skills to meet their needs. Staff were aware of the Mental Capacity Act 2005 and ensured that consent was obtained before providing care and support. Where people lacked capacity to make decisions measures were in place to ensure their human rights were respected.

People were supported to have sufficient food and drink which met their individual requirements and were assisted to see their GP and other healthcare professionals as needed.

Good

Is the service caring?
The service was caring.

People were treated with respect and kindness. Staff spoke respectfully about the people they looked after and knew the importance of good working relationships.

People were looked after in the way they wanted and staff took account of their preferences and personal choices. People were encouraged to make decisions about things that affected their daily lives.

Good

Is the service responsive?
The service was responsive.

People received the care and support they needed and staff were given clear instructions about the service they had to deliver. Reviews of the care service were undertaken regularly so people could be assured their needs would be met.

People felt able to raise any concerns they may have and would be listened to.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

People and staff said the service was well managed and that everyone ensured they were provided with a high quality care service that was safe, effective and compassionate.

People and staff said they were listened to and their views were actively sought.

Measures were in place to monitor the quality of the service and action plans were in place where improvements had been identified. Learning took place following any accidents, incidents or complaints to prevent further occurrences.

Horsfall House Homecare

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, and to provide a rating for the service under the Care Act 2014.

The last inspection of Horsfall House Homecare was completed in February 2014. At that time there were no breaches in regulations. This inspection was undertaken by one inspector as the service was a small domiciliary care service.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We also reviewed the previous inspection report and contacted health and social care professionals as part of the planning process.

We reviewed the Provider Information Record (PIR) during and after the inspection. The PIR is information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

We received completed CQC survey forms back from 28 people who use the service and two relatives or friends. They provided us with information about their experience of receiving a service from Horsfall House Homecare and we have included our findings in the body of our report.

During the inspection we visited four people who used the service and also spoke with their relatives. We spent time with the registered manager, the care coordinator, the team leader, two office based staff and three care staff.

We looked at five people's care records, five staff files and training records, electronic staff rostering records and other records relating to the management of the service. We looked at a range of policies and procedures including, safeguarding, whistleblowing, the mental capacity act, complaints and the safe management of medicines.

Good

Is the service safe?

Our findings

People said, “The staff are very competent at their job. They have to use a hoist and they know what they are doing”, “I always know who is going to call on me and I feel safe when they are with me” and “Whoever takes on the care staff knows how to pick the best. I think the care staff are of the highest calibre”. Staff we spoke with were fully aware of their responsibility to ensure people were safe.

The service had safeguarding policies and procedures in place. They gave guidance to the staff team on what to do if concerns were raised about a person’s safety, or if they were told about an event that had happened. All staff were provided with a copy of the policy and had signed to say they had read the document. Those staff we spoke with had a good understanding of safeguarding issues and had all completed a safeguarding training programme with an external training provider. Computer based refresher training was then used along with a knowledge check at the end, to ensure staff always knew what to do if abuse was witnessed, alleged or suspected. The registered manager said that safeguarding was always discussed in staff meetings and individual supervision meetings. The registered manager, care coordinator and team leader had also done enhanced safeguarding training.

Staff were aware of the providers whistle blowing policy and said they would report any bad practice to the registered manager. Since the last inspection no safeguarding concerns have been reported to us. The registered manager talked to us about a person the service will be supporting in the near future, when they return to their own home from a place of safety (the person’s choice). Meetings had already been held with social services so that care staff were aware of the issues and knew what to look out for. The registered manager was aware that if staff members were implicated in any concerns about people’s welfare, CQC would need to be informed as well as Gloucestershire County Council’ safeguarding team. This was so we could monitor what actions the service took to safeguard people they supported from further harm.

New staff were recruited following safe recruitment and selection procedures. This ensured people would not be looked after by unsuitable staff. Relevant checks were carried out before care staff started work. These checks included a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check an applicant’s police record for any convictions that may prevent them from working with vulnerable people. At least two written references were obtained from previous employers.

As part of the set-up process for a new package of care an assessment of any risks was made. This included a risk assessment of the person’s home to ensure it was a safe place for the care staff to work in. The service used a checklist provided by the Gloucestershire Fire Service to help them identify any fire safety issues in the person’s home. Moving and handling risk assessments and plans were in place where a person needed to be supported to transfer from one place to another using equipment. The safer handling plans stated the equipment to be used and the number of care staff required to undertake the tasks.

All staff received health and safety training since their employer did not manage the places in which they worked. Care staff were expected to report any health and safety concerns they had in respect of places they were sent to work. The aim of this was to reduce or eliminate the chance of accidents, incidences or near-misses. They were also expected to report any accidents or incidents that did happen.

There was an emergency contingency plan in place. This set out the arrangements to be followed if there were adverse weather conditions which disrupted the delivery of a service to the people they supported. Horsfall House Homecare had access to 4x4 vehicles and a team of volunteers in the village that could be called upon. Other examples included the loss of power and other utility services, an IT systems failure and loss of staff either temporarily or permanently.

At the time of our inspection the service were providing care and support to 78 people. A very small number of those people received help with daily living tasks and their service did not come within the remit of their registration. The staff team consisted of the registered manager, one care coordinator, one team leader and 27 care staff. In addition there were two office based administrative staff. New packages of care were only taken on when the service had the capacity to meet the person’s care and support needs.

The registered manager had recently made offers of employment to four new staff. The service had sufficient staff to meet the care and support needs of the people they

Good

Is the service safe?

supported and always allocated two care staff where they were required to complete moving and handling tasks. The registered manager and coordinator were clear that new work was not considered if staff were not available.

People were assessed when they needed help with their medicines and the level of support they needed was recorded in their care plan. Wherever possible people retained responsibility for their own medicines. The level of support the person needed was agreed upon and the person had to give their written consent to be supported. We noted that the signature was missing from one of the consent forms we looked at. Care staff received safe medicine administration training before they were able to assist people. In order to ensure they continued to support people safely with their medicines spot checks on their practice were completed. Records we saw confirmed the training and spot checks had been completed. Records were completed by the staff member following administration, these were returned to the office on a monthly basis and audited. Because of the measures in place we found that people were protected against the risks associated with medicines.

Good

Is the service effective?

Our findings

People said, "I get the service I need and was agreed upon", "I could not manage without their help. I would have to go in to a home and I want to stay here. They help me do that", "I have never been let down by Horsfall House Homecare" and "They come every day to see me and do exactly what I need them to do. I cannot fault them at all". Ninety-eight percent of the people who completed the CQC survey forms said they received care and support from familiar and consistent care staff. They also said they would recommend the service to other people, the staff had the required skills to do their job effectively and all tasks were completed.

Staff told us about the people they supported. They were knowledgeable about the tasks they had to complete for people and their preferences and daily routines. They told us that on the whole they went to the same people on a weekly basis so, "We can get to know them well" but their work plans did change if people, or staff were away or there was an extra need for support because someone was unwell. It was evident that people were generally looked after by staff who were familiar with their needs.

People were supported by care staff who received the appropriate training to enable them to fulfil their role. New staff completed an induction training programme when they first started working for the service. This programme met the requirements of the Care Certificate and consisted of the 15 modules to be completed within a 12 week period. The registered manager monitored progress and completion of the modules.

There was a staff training programme in place. All staff had to complete refresher training after specified periods of time. Examples included dementia awareness, safeguarding, health and safety, first aid, safe medicines administration and moving and handling. Individual training records were maintained for each staff member. Person specific training would be arranged where needed to equip support workers with the required knowledge and skills to meet that person's needs. The service used a combination of methods to provide the training, an external training provider, attending training sessions with the staff from the nursing home on the same site and by using e-learning, DVD's and workbooks.

Staff were encouraged and supported to complete further health and social care qualifications (formerly called a National Vocational Qualification (NVQ)). There was an expectation that all staff would complete a level two diploma in health and social care. Twelve care staff had achieved a level two award. The coordinator, the team leader and eight other care staff had achieved level three awards. The registered manager had achieved a level four award and the registered manager's award.

Staff were well supported and could contact the office or the on-call person at any time. They had regular supervision meetings with the registered manager and also staff meetings. Spot checks were undertaken to ensure the care staff were delivering the service that was expected of them. Annual staff appraisals were used to discuss work performance and any training and development needs.

Staff gained people's consent before starting to provide assistance. They completed a computer based training session on the Mental Capacity Act 2005 (MCA) and had a good understanding of consent issues. The registered manager, coordinator and team leader had attended enhanced MCA training. All staff were provided with a 'prompt card' that detailed the principles of the MCA. The MCA sets out what must be done to make sure the human rights of people who lacked mental capacity to make decisions were protected. A person's ability to give consent was assessed as part of the overall assessment process. The registered manager talked about one person who lacked capacity, where an Independent Mental Capacity Assessor (IMCA) was involved. This was to ensure the person's human rights were heard and decisions were made in their best interest.

Where people required support from the service to eat and drink the amount of support they needed was assessed and included in their care plan. People could be provided with support to prepare meals and drinks or be supported to eat their meals. Care staff delivered meals that had been prepared in Horsfall House nursing home to those people where this had been agreed. Care staff said they would report any concerns they had about people's eating and drinking to the registered manager so that their concerns could be passed on to healthcare professionals.

People were registered with their local family GP and support staff helped them make appointments and arrange for repeat prescriptions as part of their care plan. Where people were supported by other health and social care

Good

Is the service effective?

professionals, the service and staff worked alongside them to make sure people were well looked after. Examples included working with an occupational therapist, social workers and community psychiatric services. One healthcare professional reported the care staff refer problems and concerns regarding their patients promptly and effectively.

Good

Is the service caring?

Our findings

People said, “The girls from Horsfall House Homecare are pretty good”, “All the staff are very kind and polite. There has never been any rudeness or unkindness” and “I have only ever used this agency but I am very satisfied, the staff are trustworthy, friendly and very discreet. They never talk about others that they visit”. Ninety-three percent of the people who completed the CQC survey forms agreed or strongly agreed that they were treated with respect and dignity by the staff. One person commented, “The fact that the care staff are so friendly and kind to me has made it easier for me to accept that I need help to stay in my own home”. It was evident from speaking to care staff and the office based staff there were positive working relationships with the people they supported. One relative contacted us after they had been sent a CQC survey form. They said they had received help from the service for six years and “they (the staff) are all friends now after six years”.

We overheard several conversations with one person who used the service. The person was anxious and the conversation was repetitive, but the office staff handled the calls sensitively and calmly. People were treated as individuals and with respect and dignity at all times.

People were looked after by the least number of care staff possible. Where people had large packages of care, for example three or four visits per day the registered manager aimed for a small group of care staff to support them. Where people required two care staff for a call, at least one of them would be familiar with the person, their needs and the particular way they liked having things done. Care staff told us they called in to the office beforehand if they were scheduled to visit a new person to read the care plan fully. Because of the way that care staff were scheduled it meant that they were able to get to know people well and were knowledgeable about how they liked things done. Care staff demonstrated a genuine caring attitude towards the people they looked after.

People had a say in how they wanted to be looked after and were fully involved in the assessment process. They were asked by what name they preferred to be called and this was recorded in their care plan. One person told us, “Although I asked to be called by X, new staff that come to me refer to me as Mrs.…., they ask for my permission to call me by my first name”. Each person received a service that was based upon their individual and specific needs. There were key times of the day that were more popular requests (morning get ups etc) and these had to be negotiated to everyone’s benefit.

Those people we met told us they always knew who was going to be supporting them because they were sent a weekly rota, either by post, email or given the details verbally over the phone.

Where required the service would support people who were at the end of their life to remain in their own homes. They would need to work in conjunction with community health care services and families in order to achieve this.

Good

Is the service responsive?

Our findings

People received the service that had been agreed upon when the service was either first set up or had been agreed during a review meeting. People said, “The coordinator came to see me and we discussed what sort of help I needed”, and “I have never had a call missed. The staff are very reliable”, and “I receive the exact service I need. It helps my family to know that the care staff are looking out after me”, and “The service is provided for my wife but the care staff look after me as well”. One person told us the service did their very best to be flexible if they asked for temporary changes to be made because of family visiting or hospital appointments this was accommodated. People who completed the CQC survey forms agreed or strongly agreed that they were involved in decision making about their care and support and knew how to raise any concerns they may have. Relatives who completed the CQC survey forms said they had been consulted (in agreement with the person receiving the service) in setting up the service.

New packages of care and support were only taken on when the service had the capacity to meet the needs of the person. This decision was made by the registered manager and the team leader. An assessment of the person’s care and support needs was undertaken before the service started in order to determine what support was required. This was to ensure any necessary equipment was in place and to ensure staff had the necessary skills. The assessments were completed by the coordinator however the registered manager was involved with complex cases.

A care file was kept both in the office and also in the person’s own home. The files included the care plan and a timetable showing when a service was to be provided. For each of the visits details of the tasks to be completed were recorded. Care staff were provided with clear instructions about what they had to do.

All new care and support packages were reviewed after a six week period and then on a yearly basis. This review programme was amended if a person’s care and support needs changed and the support provided needed adjustment. The review was undertaken with the person and any family or health and social care professionals as appropriate. This meant people would be provided with the support they needed to remain in their own homes.

People were provided with a copy of the service user guide. This included a copy of the service’s complaints procedure. We asked people if they felt able to raise any concerns they may have. They told us, “I raised a concern a while back and it was dealt with straight away. Everyone is keen to get things right and sort things out if we are not satisfied” and “I did speak to the office once and the issue was resolved straight away”. It was evident that people felt able to raise any concerns they had with the staff and they were listened to. People were able to give feedback about the service they received at other times such as when their care reviews took place and when they were sent ‘customer survey forms’.

The registered manager and team leader were aware that some reorganisation of the care runs were required in order to make best use of care staff time and travel time in between people. Several people commented that “care staff were not always given sufficient travel time”.

Good

Is the service well-led?

Our findings

People said, “The service is well-led”, “It must be well-led because they have never let me down”, “I get the exact service I expect” and “I always receive a first class service. I am very lucky because from what I see on the news, not all services and care staff are as good as Horsfall House Homecare”.

Ninety-eight percent of people who completed a CQC survey form said they knew who to contact in the service if they needed to and had been asked to provide feedback about the service they received. Health and social care professionals who responded to our requests for feedback about the service said, “The registered manager manages a very professional service and actively takes part in the Gloucestershire Care Providers Association” and “The coordinator and team leader are professional and helpful and provide strong effective leadership.

The registered manager and staff said things had been very difficult towards the end of 2015 because of difficulties in recruiting staff to meet the demand for service provision. Four new staff had been recruited plus there was an ongoing recruitment programme. The registered manager said that despite these difficulties no calls had been missed and every person received the service they expected.

Office staff included the registered manager, two administrators, the team leader and a coordinator. Each member of staff had a specific job role. The team leader was responsible for organising the staff duty rotas and ensuring that each person received the service they expected. The coordinator undertook the new ‘set-up’ assessments, reviews and spot checks on staff work performance. One of the administrators did payroll and invoices for people who received the service. The other administrator identified and booked staff on refresher training, and identified which people were due for care plan review and staff for spot check review.

Out of office hours there was an on-call system for management support and advice. Staff said the arrangements worked well. The on-call cover was provided by the registered manager, coordinator, team leader and senior care staff. One member of care staff was allocated to be on “stand-by” at the weekends. These arrangements were in place to cover last minute sickness or any emergencies. Management support was also provided by the Horsfall House general manager (registered manager for the nursing home).

A number of different methods were used to assess the service and check it was meeting its aims and purpose. Records including medicine charts and daily notes were checked when they were returned to the office. The registered manager analysed any accidents, incidents or complaints received and looked for any trends. This enabled them to make any improvements and prevent reoccurrences. The service had received one formal complaint in 2015 and their records showed that the issue had been handled in line with the complaints procedure.

Staff said they were able to make suggestions about how things could be done better and were listened to. They felt their views and opinions were valued and respected. Feedback from the team about how things were going and suggestions about meeting people’s needs was encouraged. Staff knew the service had a whistle blowing policy and there was an expectation that they would report any bad practice.

Feedback was obtained from people using their services and relatives, during care plan review meetings and survey forms. Information from both methods was acted upon and used to make changes to the benefit of people using the service.

The registered manager was aware when notifications had to be sent in to CQC. These notifications would tell us about any events that had happened in the service. We use this information to monitor the service and to check how any events had been handled.

The registered manager had weekly meetings with the trustees’ nominated person (the general manager) and reported on how the service was doing and any significant events. The registered manager prepared board reports on a quarterly basis and reported on the number of people being supported, staff changes, any significant events, accidents and incidents and any complaints received. These measures ensured that the board of trustees were kept informed about the quality and safety of the service provided.