Mrs Stella E Davies

Safe & Sound Homecare Services

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook this comprehensive inspection on the 20 of August 2018 and it was announced. This was because this service provides care to people in their own homes and we needed to ensure senior staff were available to speak with us. This was the first inspection of the service since it registered with the Commission.

Safe and Sound is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, some of who may be living with dementia.

Not everyone using Safe and Sound 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 the time of the inspection, there were 67 people receiving personal care from the agency. Safe and Sound provides care and support in the Radstock area.

The service had 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.

The staff did not work within the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Capacity assessments and best interest decisions were not always in place where required. There were inconsistencies in seeking and recording consent for people with fluctuating capacity. Care records lacked detail on the specific decisions people who were assessed as lacking capacity would require support to make. Staff told us they sought people's verbal consent before they provided care and support and recognised this was an important part of their role in promoting choice and independence.

Some people took responsibility for their own medicines management while staff supported others. For those who needed staff support, there was no audit of record to ensure staff had signed to indicate they had given people the prescribed medicine. There were no PRN protocols to inform staff when to offer people medicines that they may take 'as required'.

People were supported by staff that were competent and had received training to ensure they had the skills and knowledge to carry out their roles. Staff received supervision and appraisals and felt recognised for their work.

People were supported by staff who used personal protective equipment correctly to reduce the risk of cross infection. Care plans contained risk assessments which identified potential risks to people. However, care plans were not person centred and did not contain important information relating to preferences or detailed routines required for staff to provide consistent and safe care.

People were supported by staff who had checks undertaken prior to being employed by the service. There was sufficient numbers of staff and people received support from a consistent staff team who were familiar with their needs.

Staff could demonstrate a good understanding of abuse and who to go to should they have concerns. Staff were kind and caring. Relatives told us they were notified whenever changes in their relative's condition had happened, and health professionals were referred to for advice and treatment.

Feedback and views of people using the service were sought and people and relatives were complimentary about the office management team. They felt able to raise concerns with the registered manager who they felt was accessible.

The service had a quality assurance system which had not identified shortfalls in the medicines administrative records audit. Care plan audits had not identified inconsistences in the recording of people's mental capacity.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People received their medicines from staff who had received training. However, there were no 'as required' medicines protocols to guide staff.

Staff knew about safeguarding procedures and understood what action to take if they suspected abuse.

There were enough staff to meet people's needs and people's care hours were provided at the times people needed.

People were support by staff who knew them well.

Is the service effective?

Requires Improvement

The service was not always safe.

People received their medicines from staff who had received training. However, there were no 'as required' medicines protocols to guide staff.

Staff knew about safeguarding procedures and understood what action to take if they suspected abuse.

There were enough staff to meet people's needs and people's care hours were provided at the times people needed.

People were support by staff who knew them well.

Is the service caring?

Good

The service was caring.

Staff were respectful of people's privacy and dignity.

Staff were committed to promoting people's independence and supporting them to make choices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans lacked full information to support staff to provide personalised care.

People's care plans did not contain important information relating to their likes and dislikes, and how they wanted to receive their care which was personal to them.

People's communication needs were not always recorded. This meant peoples support needs were not always understood.

People and relatives were involved in their care plan reviews and all were happy with this involvement.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had quality assurance system in place but these were not effective in highlighting shortfalls found during this inspection.

People's views were sought through regular reviews and annual questionnaires.

People and staff felt the management were supportive and accessible and there was a positive culture.

Safe & Sound Homecare Services

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 20 August 2018 and was announced. We gave the service 48 hours' notice of the inspection visit. The inspection was carried out by two inspectors 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 looked at the information in the PIR and also looked at other information we held about the service, which included notifications they had sent us. A notification is information about important events, which the provider is required to send us by law.

During this inspection we visited the provider's office. We spoke with the registered manager, care manager, office manager, administration staff and four members of staff. We also spoke face to face with one relative and three relatives on the telephone. We looked at a range of records during the inspection. These included seven people's care plans, medicine administration records, staff rotas, five staff recruitment files, staff training records and quality monitoring records. We visited two people with their permission in their own homes, and spoke with seven people following the inspection on the telephone.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. During the inspection we saw some Medical Administration Records charts (MARs) with missing signatures. It was not clear if the person's medicine was administered. The care manager confirmed that no medicine checks were carried out, such as a check of monitored dosing systems, signatures on MARs charts or checks that creams and lotions remained in date. Some people had been prescribed additional medicines on a 'as required' (PRN) basis, such as pain relief. Although the observed staff were heard offering PRN, there was no record of the PRN protocol to guide staff as to how and when these should be administered. This meant for example where people could not express their pain or those who could not remember they had the medicine, unfamiliar staff would not know when or why people might require PRN medicine.

Staff were trained in medicines management and there were clear instructions for staff on where and when to apply topical creams and lotions. However, no other medicine checks were carried out or checks to confirm that creams and lotions remained in date. The service did not have a documented procedure on what action was taken when missed signatures were found.

Staff supported some people to take their medicines and others could do this independently or with family support. When staff did support people with medicine, the care plans provided detail on the level of support people required. For example, staff dispensed some people's medicines and gave it to them. On other occasions staff prompted people to do this themselves.

People and relatives felt safe. Comments from people using the service included, "I am very safe with the staff". Another person said, "Safe and Sound with the staff, I don't worry about them coming, I know they will be alright". Another person said, "I feel safe as houses with the staff they know what they are doing". One relative told us, "My [Name] is really safe around the staff, [They are] never worried, never upset, always happy when staff have been". Another relative said, "Nothing to grumble about".

People were supported by staff who had checks undertaken prior to starting their employment. For example, checks included verifying the member of staff's identification, references and undertaking a disclosure and barring service (DBS) check. A DBS check confirms if the individual has any past record that might make them unsuitable to work with vulnerable people.

People were supported by staff who could demonstrate their understanding of abuse and what action they would take if they had concerns. Comments from staff included, "I would write it down, and report it to [manager's name]" and "I would record bruises on a body map, write it all down and inform the office immediately. They then investigate and report it to the local safeguarding team." Staff had access to the provider's safeguarding policy which was in the care office. The service made safeguarding alerts when required. Staff were also familiar with the term, 'whistleblowing'. All staff felt confident to raise any concerns about poor care and all said they believed any concerns would be taken seriously. One member of staff said, "We did it in our training. I'd speak up."

Care plans contained risk assessments which identified potential risks to people. These included assessments of the person's home environment. People had also been assessed for the risks of falling, moving, choking and managing medicines. When risks were identified, records guided staff on how to reduce the risk and support people safely. For example, one person's risk assessment confirmed the equipment they required and how staff needed to support the person to ensure the person was using it correctly.

People were supported by staff who were clear on their responsibilities for reporting and recording accidents and incidents. The registered manager analysed all incidents and accidents monthly. This was so any trends could be identified to prevent similar situations from occurring again. Actions taken were recorded and lessons learned from the incident or accident were shared with the team. For example, one staff member had slipped on a step going into one person's house. All members of the team had subsequently been informed to read the associated risk assessment and to follow the guidance to prevent a recurrence.

People were supported by adequate numbers of staff and sufficient time was allocated to meet their individual needs. People told us they received regular staff who they were familiar with and they arrived when they should. One person told us; "The carers always arrive on time depending on the traffic and never cut the visits short". One relative commented, "They come to see my [name] at various times during the day, they are never late and stay with my [name] for as long as they should". Staff also confirmed they were given travel-time between visits and had enough time allocated with people. One member of staff told us, "If we [staff] think people need a longer time slot, we just tell the office and they get it sorted". The service used a scheduling system to allocate staff to people and try to keep staff in the same area so people received care from staff who were familiar with their needs. Staff told us, "Geographically, they're trying to keep us all in a small area, which is working well."

There was an on-call service for staff and people to access out of hours. Staff felt this was effective. Staff told us, "The on-call team is good. If you ring, they'll always answer and come out and help you if needed". Another member of staff told us, "There is always somebody on-call or we can call [Care Manager]. In a real emergency I know to call the GP or an ambulance."

People were supported by staff who had a good understanding of infection control procedures. Staff confirmed they wore gloves and aprons whilst supporting people and washed their hands after providing care to people.

Requires Improvement

Is the service effective?

Our findings

"The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People's care plans did not confirm if people with fluctuating capacity had been assessed. This is important as people who have fluctuating capacity may not always be able to make decisions about their care and treatment. For example, one person had a medicines risk assessment which recorded the person lacked capacity. They had a consent form signed by them which confirmed they had capacity and gave permission for assistance with medicines. These records gave conflicting information and it was not clear if the person did or did not have capacity to make this decision. In addition, where capacity had been identified as fluctuating or lacking, no best interest decisions had been recorded to ensure that the support provided was least restrictive.

Care plans documented when people had appointed a lasting power of attorney (LPA), but had not always written which type of LPA was in place. For example, property and finances and/or health and welfare. In one person's care plan, staff had written the person's relative had LPA for finances and yet they had signed the consent forms for the person's care, which this type of LPA does not authorise them to do. However, staff understood the principles of the Mental Capacity Act. For example, staff told us, "I always ask people what they want, give them choices, and make sure I speak to them face to face. I might pull out several outfit choices for example". Another member of staff said, "It's got to be about giving people choices about everything."

We recommend the provider reviews their processes in line with the MCA 2005 Code of Practice.

People were supported by staff who received supervisions and an annual appraisal. Supervisions were a combination of observed spot checks or face to face meetings. Staff felt able to approach the registered manager in between their supervision sessions. Staff said they had supervision sessions with a line manager. One member of staff said, "I'm not sure how often I have them, but I can ask for support in between if I need it." Another member of staff said, "I seem to have supervisions quite often. We discuss any issues, general support. If I have a problem, I can speak up". Supervisions were an opportunity to discuss topics such as information on issues affecting people or the member of staff, conduct, training and development needs. The registered manager monitored the service's performance to ensure that each member of staff had their supervision when required.

Staff had received training to enable them to support people competently. Staff had completed training in safeguarding adults, moving and handling, dementia and health and safety. This was part of the provider's mandatory training programme. Staff said they had access to training and felt they had the necessary skills to undertake their roles. One member of staff said, "I've done medication, first aid, equality and diversity and

dementia training". Another member of staff said, "I'm due to attend the new safeguarding training next month". Another member of staff said, "Oh my goodness, we have lots of training". Staff also received additional training to support people with their individual needs. For example, staff records confirmed staff had received training in balloon colostomy care to support a person with a stoma bag and their bowel care.

Staff knew people well and had received training to support people with their individual nutritional and hydration needs. People were supported to have enough to eat and drink. When required staff prepared meals and drinks for people. Where people had individual specific needs relating to their nutrition and hydration this was recorded in the person's care plan. During the inspection we observed staff offering people a choice of two meals and prepared it. A relative for another person explained "My [name] has dementia, they look after her and help her to get lunch, my [name] is left to eat it in peace and she can manage to do her own washing up". In addition, one member of staff said, "One person I go to see isn't eating so well. I'll ask [Care Manager] to start a food monitoring chart and I know it will be acted on." People received support to keep them healthy. Where people's health had changed appropriate referrals were made to specialists. One relative told us, "If [person] isn't well or running out of medicine [care worker] calls the GP. She calls the pharmacy if the dossette box has a problem". One care worker told us, "In supervision I raised that [name] was struggling with standing. [Care Manager] made a referral to the occupational therapist. After the occupational therapist assessment [name] was given standing aid equipment." Staff could support people to contact the GP if they felt unwell, or call the emergency services if they found a person in distress.

Good

Is the service caring?

Our findings

People and relatives felt staff were kind and caring. People were happy with the care they received. People told us, "The carers are very nice people, always polite and they really smile a lot". Another person told us, "The staff are good, kind and polite, they take time to listen, you can talk to them about anything". Another person said, "The staff know me so well, they are always kind and polite towards me, my family and friends". One relative told us, "The staff attitude is very positive, they seemed to be well trained and enjoy their jobs."
The service had received many compliments about how caring the staff were. Examples of these included, "[name] was adamant that it was your agency they wanted to be looked after. Having met your carers, I can understand why. Staff have gone out of their way to give compassionate and empathetic care". Another comment included, "Thank you for all the help and support you provided both for [name of person] and myself". Another comment included, "I would like to thank you and your staff, especially [staff name] who mum became very close to for all your support."
Staff spoke passionately about their roles. All the staff we spoke with said they provided, good care." One member of staff told us, "I treat people exactly how I would treat my own mum or dad. It's the extra things we do that make a difference. So, if someone tells me they're running low on milk, I'll bring a pint with me on the next visit, or if there's a problem with their television, I'll retune it for them."
People felt staff maintained their dignity and respected their privacy. One person told us, "The carers all call me by my name, when they come, they knock on the door and call out so I know who it is before they come in". Another person said, "The staff all of them respect that this is my home, I know them so well". Staff understood how to maintain people's privacy and dignity. Comments included, "I always make sure people are clean and smart" and "When I wash someone, I wash the top half first, and then dry them and dress them before doing the bottom half. I wouldn't want to be exposed if it was me". During the inspection we observed staff knocking before entering a person's house and talking with the person in a positive way before commencing personal care.
People felt supported by staff who knew them well. People told us, "The carers know me well and my funny little ways". The registered managed tried to keep people with a regular staff team. This meant people were supported by staff who were familiar with their individual support needs. This was confirmed by staff who commented, "I love my job so much. We do everything to keep people at home for as long as possible. We get lots of continuity; we know our clients and they know us". Another member of staff told us, "The clients are like my extended family". Staff felt well informed about any changes to people they support. The registered manager told us staff were prompt at calling the office if there was a change in people's needs. She also confirmed there was a text system to let staff know of any changes or updates about people's care.
We saw staff promoted people's independence by encouraging them, where possible, to do things for themselves. This included eating and drinking. We observed staff cutting up food into small pieces for someone who had swallowing difficulties. This enabled them to eat on their own with a reduced risk of choking and remain in control. During our inspection, we observed staff encourage a person to use their walking frame to enable them to maintain their mobility.
People were supported by care staff who could demonstrate an understanding of equality and diversity. One member of staff told us, " We respect everyone, we don't discriminate even if they are disabled, older or different religion. At the moment I don't support anyone of a different culture but we treat people equally regardless."

Requires Improvement

Is the service responsive?

Our findings

People's care plans were not always person centred as they did not contain important information relating to people's choices. This meant there was limited information recorded for staff to know people's preferences. For example, care plans did not detail people's preference relating to their preferred toiletries, whether gentlemen preferred a wet or dry shave or whether ladies liked to wear jewellery or make up. People's clothing preferences were also not listed. Although the plans guided staff to prepare people's meals, they did not detail people's likes and dislikes around food or drink preferences. Despite this, staff knew people well and had become familiar whilst supporting people with their individual care needs. One staff member said, "The care needs to be all about the person. Some of it I know, but it's just not written down". This meant the lack of documentation of people's likes, dislikes and their preferences, would result in inconsistent care. Care workers that were not familiar with the person would not have full information to ensure they provided care in line with their preferred support.

The plans did not always provide enough detail for staff on how to respond to people. For example, in one plan it was documented the person "Doesn't recognise the need to carry out personal care regularly and can forget." The guidance for staff was limited to, "Guide and support [person's name] to maintain a good level of hygiene." There was no explanation for staff on how to provide the support. The same person's plan informed staff to provide, "Reassurance if anxious or upset" but did not explain how staff should do this.

Communication plans were in place, but did not always provide enough information for staff on how to ensure people's needs were understood. For example, although in one person's plan it was written that staff should speak loudly and clearly because the person was hard of hearing, information such as informing staff to face the person when speaking was not included. In another person's plan it was written that they could communicate their needs but that they "sometimes struggles to get words out." The only information for staff was limited to "Requires time to digest information and communicate views, wishes and feelings."

No one was receiving end of life care at the time of the inspection. People's care plans did not record people's spiritual, emotional or end of life wishes to enable staff to follow these if needed.

The service had a complaints procedure which was presented in a user-friendly format and provided to people when they commenced using the service. Where people may need support to express a complaint or concern an independent advocate or family members were suggested to act on behalf of people, and promoted by the service. Complaints were logged so that the registered manager could review them to prevent any similar trends from occurring. Six complaints had been received during 2018. All had been investigated and resolved within the provider's specified timeframe. One relative told us, "There is nothing to grumble about, but our son would talk to the office if we were worried about my [name] care and it will be sorted". All people we spoke with were happy with their care and felt able to raise any concerns or complaints with the management of the service. People's care plans confirmed people had received the terms and conditions of the complaints and compliments procedures.

Care plans had been regularly reviewed and people and their relatives had been involved in planning their

care. People told us, "I am involved in all aspects of planning my care, every step of the way". Another person told us, "The manager comes around to check up on the care staff and to talk about my care plan". One relative told us "Me and my [name] get involved in the review of the care plan on my [name] behalf as she has dementia, we discuss this with the manager". People's life histories had been included in plans. This meant staff had access to information about people's lives prior to receiving support at home.

Requires Improvement

Is the service well-led?

Our findings

The provider's systems to monitor the quality of the service had not been effective to identify and deal with shortfalls identified at this inspection. The registered manager and the service manager checked people's care records to ensure documentation was accurate and up to date. However, when issues had been noted by the care delivery service audit, there were no action plans in place. For example, shortfalls had been identified that staff were not writing in black ink. This had been identified in every audit since 2014, but had yet to be resolved.

Medicines audits were not robust at identifying shortfalls found during the inspection. The care delivery audit tool in use had one question relating to medicines which read, 'Do records demonstrate medication management as required?'. We discussed this with the care manager who confirmed no other medicine checks were carried out, such as a check of monitored dosing systems or checks that creams and lotions remained in date.

Systems for the oversight of care plans were ineffective. The care manager reviewed care plans annually but had failed to identify the lack of detailed information relating to people's personalised care. In addition, care plan audits had not identified inconsistences in the recording of people's mental capacity. They had not identified that a best interest's decision document had not been completed for a person who was assessed as having fluctuated mental capacity to make their own decision. In addition, the audit had not identified a medication consent form that had been signed by a person who had a capacity assessment which indicated that they lacked capacity. Additionally, the audit had not been robust enough to identify that a relative with Lasting Power of Attorney for finance had given consent for an issue relating to health and welfare, without the appropriate authority.

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

All people and staff spoke highly of the management of the service and the quality of care received. People described management as, "Open", "Friendly", "Caring" and "Approachable". People told us, "You can call the office anytime everyone is so friendly, the management are very good, they come around to see me from time to time and seem to really listen to what I have to say". Another person told us, "The manager is open and approachable, they know the job and do it well, no concerns at all". Staff said they felt well supported and enjoyed working for the provider. One member of staff said, "This is a family run business; it works well." Another said, "[care manager] is flexible and approachable."

The service had a positive culture with clear management. The service was managed by a registered manager who was supported by a care manager who ran the day-to-day operations of the service and an office manager who dealt with the administrative and financial part of the business.

Staff were provided with weekly updates. These included updates on people using the service as well as general information the provider wanted to share with the team. Staff said they had regular team meetings

where they felt able to speak up. One member of staff said, "We meet up all together every few months". Another member of staff said, "We're a small team, but we're listened to". However, one staff member said, "We don't get to see each other much. There's some new staff who I've never met. I don't think we meet up often enough".

People's views were sought regularly. People were asked if they were happy with the care they received. The care coordinator called people once a month and tried to see them at least once every quarter to check if they were well or if they needed anything changed in their care plan. This ensured that any concerns were identified and actions taken before the concern escalated into a complaint. An annual quality assurance survey was used to monitor the overall care experienced. This meant people's views were sought so that improvements could be made. Feedback received confirmed people were highly satisfied with the care they experienced and that they felt staff were provided adequate training and staff were competent.

The registered manager understood the requirements of their registration with the CQC and ensured that we were informed of notifiable events that occurred at the service. The care coordinator also told us that they worked in partnership with the local authority commissioning team.

Staff were recognised and felt valued working for their service. One member of staff said, "I feel valued. If I do extra hours, [Care manager] will always ring and say thank you."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure that systems and processes were established and operated effectively to ensure compliance with the required regulations Regulation 17 (2) (a) (b) (c)