Interserve Healthcare Limited

Interserve Healthcare - Sheffield

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 26 September 2016 and was announced. This was the first inspection for the provider at this location which was registered in December 2014.

Interserve Healthcare – Sheffield is operated by Interserve Healthcare Limited. They provide a domiciliary care service that supports people with personal care and day to day living in the Sheffield area. The service currently provides care to six people who have complex care needs and require large packages of support, some of which are 24 hours a day, seven days a week. The service is also registered to provide nursing care but does not currently carryout this activity.

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

Care staff were confident about how to protect people from harm and knew what to do if they had any safeguarding concerns. We found that some safeguarding concerns which had been reported to the local authority had not been reported to the CQC as required. We have dealt with this issue separately. Although there were quality monitoring processes in place, the issue regarding failure to report to CQC had not been identified. We have made a recommendation about this.

The registered manager had good oversight of the service and was experienced in their role. The provider had a clear set of visions and values which were promoted within the organisation. There were systems in place to seek the views of people who used the service and their relatives.

Risks to people had been assessed and plans put in place to keep risks to a minimum. An 'out of hours' service was in place so that people could contact a member of staff when the office was closed. Medicines were managed safely and people were supported to take medicines as prescribed.

The provider had robust recruitment procedures to make sure staff had the required skills and were of suitable character and background. There were enough staff available to make sure people's needs were met. The provider was constantly recruiting new staff in order to make sure that there was a suitable match

between care staff and the people they supported.

People were cared for by competent staff. Staff were supported through training, regular supervisions and team meetings to help them carry out their roles effectively. There was an open and accessible management team.

The manager and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS are put in place to protect people where their freedom of movement is restricted. People were supported to consent to the care provided.

Care staff were caring and treated people with respect. Care plans were person centred and showed that individual preferences were taken into account. Care plans gave clear directions to staff about the support people required to have their needs met. People were supported to maintain their health and had access health services if needed.

People received support which was regularly reviewed and met their current needs. People who used the service and their relatives had opportunities to make comments about the service and how it could be improved. Any complaints were investigated and complainants were provided with a written response.

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.

There was safe management of medicines which meant people were protected against the associated risks.

Staff were confident of using safeguarding procedures in order to protect people from harm.

Risks to people had been assessed and plans put in place to keep risks to a minimum.

There were sufficient numbers of staff to meet people's needs. Recruitment procedures made sure that staff were of suitable character and background.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the knowledge and skills necessary to carry out their roles effectively.

Staff understood the requirements of the Mental Capacity Act 2005 and relevant legislative requirements were followed.

People were supported to maintain good health and were supported to access relevant services such as a GP or other professionals as needed.

Is the service caring?

Good

The service was caring.

People told us that they were looked after by caring staff.

People, and their relatives if necessary, were involved in making decisions about their care and treatment.

People were treated with dignity and respect whilst being supported with personal care.

Is the service responsive?

Good

The service was responsive.

People received personalised care. Care and support plans were up to date, regularly reviewed and reflected people's current needs and preferences.

People could make a complaint or compliment about the service. Complaints were investigated appropriately. There were opportunities for people to feed back their views about the service.

Is the service well-led?

Requires Improvement

The service required improvement to become well-led.

The systems in place to look at the quality of the service provided were not fully effective at identifying shortfalls in order to improve practice. The CQC had not always been notified about safeguarding concerns, as required.

The service had an experienced, registered manager in place.

The service had clear visions and values.

Interserve Healthcare - Sheffield

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 26 September 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection was carried out by two inspectors.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We also looked at previous inspection reports. We reviewed the Provider Information Record (PIR). The PIR 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.

During this inspection we visited the office and looked at records which related to people's individual care. We looked at three people's care planning documentation and other records associated with running a community care service. This included four recruitment records, complaints, notifications and records of meetings. We spoke with the registered manager, deputy manager, branch nurse, a senior carer and two care staff. After the inspection we spoke with four relatives, one person who used the service and nine care staff over the phone.

Prior to the inspection we contacted Healthwatch to ask if they had any relevant information for the

inspection. We also sought the views of Commissioners who funded packages of care although we received no feedback.

Good

Our findings

The people we spoke with raised no concerns about their safety. Staff were confident about identifying and responding to any concerns about people's well-being. Staff had received appropriate training in this area to support their understanding of safeguarding. One member of staff said, "Any concerns are passed straight to management. They usually come to see the client" and another told us, "Any concerns, I discuss with a manager as it may be safeguarding". Staff had an understanding of whistleblowing procedures should they have any concerns about practice within the organisation.

A record of any accidents or incidents was kept at the office. There was a clear record of events and the action taken in response. Safeguarding concerns were alerted to the local authority safeguarding team as necessary. However, we identified four safeguarding alerts in 2016 that had not been reported to the CQC as required. We spoke with the registered manager about this who agreed that they should have been reported and subsequently submitted notifications retrospectively. They told us they have reminded office staff of notification requirements.

The service had clear and up to date policies and procedures relating to health and safety. These provided guidance for care staff on how to work in ways that kept themselves and people using the service safe. Each person had personalised risk assessments in place to ensure staff were aware of how to reduce known risks and ensure the safety of the person. Risk assessments covered clinical procedures as well as areas such as moving and handling, assistance with medication and skin integrity. For example, one person's record showed clear guidance about the risks associated with feeding someone through a tube attached to their stomach (Percutaneous Endoscopic Gastronomy or PEG feeding). This included information about how to clean the tube and what to do if it became blocked. Care plans evidenced that equipment was checked regularly to make sure it operated safely.

The deputy manager described one of the ways in which risks were managed. They described how the service tended not to use hot water bottles because of the risk of scalding. If a client requested one, they would get written agreement form the person's doctor prior to their use. They added that they recommended the use of wheat bags and completed a risk assessment for their use.

An environmental risk assessment had been undertaken in each of the properties where people lived. This included lighting conditions, accessibility to property and safety of floor coverings. This provided staff with information to keep themselves and others safe when visiting people. We saw these assessments were regularly reviewed and updated when required.

Medicines were managed safely. Some people who used the service were unable to take their own medicines safely and relied on staff to make sure they took their medicines as prescribed. This is called medicine administration. Each person who needed their medicine to be administered by staff had a Medication Administration Record (MAR). Some people had their medicines prepared in 'blister packs' by a pharmacist in addition to other boxed medicines and creams.

The deputy manager explained that they supported six people with medicine administration. Care staff received appropriate training and were assessed as competent before being able to administer medicines. An update from each person's doctor was requested every month to make sure there were no changes. The deputy manager also checked MAR sheets every month to make sure there were no errors.

The MAR that we looked at were clearly recorded and matched the information in care plans. There were no unexplained gaps in recording. We identified no concerns with medicines management from the feedback we received.

Some people had medicines to support them after having an epileptic seizure, often administered rectally. Responsible staff had received specific training in the administration of this type of medicine. Each MAR also included guidance, specific to each individual, on the use of this medicine.

Staff files demonstrated that the provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, previous employer references and a Disclosure and Barring Service check [DBS] which was carried out before staff started work at the service. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. The deputy manager told us that as a policy, they did not recruit anyone with less than six months experience of care in the UK to make sure they were sufficiently experienced.

Some people who received a high level of support had a team of staff who supported them. We received feedback from two relatives that their team was not at the number which had been agreed during the assessment and that this made it difficult to provide consistent support, particularly if there was absence at short notice. We asked the registered manager about this and they confirmed they were aware of the issue. They explained that they were continually trying to match suitable care staff with people who used the service and it was important to give people a choice about who they wanted. They added that, on occasions, the staff offered were turned down by people or their relatives as not being a suitable match. This was confirmed by one relative who said, "We are very particular about who provides the support". The registered manager told us that they were constantly trying to recruit suitable staff and a manager was in regular contact with families where this was a concern. We did not find any evidence to suggest that this meant the care provided was unsafe.

Rotas were in place on an electronic system which showed how many staff should be supporting people at each call. Staff availability was requested six months in advance in order that the service could plan effectively. There was an on call system which provided both physical back up to care staff and telephone support. Every morning and evening there was an 'on call 'handover to ensure any issues had been resolved or contingency action could be taken or planned.

Good

Our findings

Staff told us that they enjoyed their work and felt supported to provide an effective service. Comments included, "I'm happy with it. If I need help it is there", "I feel supported" and "Support is quite excellent". People and their representatives said they were happy with the care staff who supported them. Feedback included, "The carers are spot on. Dedicated", "The current support workers work hard and are good with the support" and "Staff are brilliant".

Staff were supported with a comprehensive induction when they first started working for the service. This included training in core areas such as safeguarding, manual handling and infection control. Staff were also given the opportunity to shadow experienced staff in order to become familiar with their role. Records showed that new staff were supported to complete the Care Certificate. This is a set of standards for social care and health workers, which covers minimum standards that should be part of induction training of new care workers.

Core training was refreshed each year. The staff we spoke with confirmed this. One staff member commented, "We are sent reminders when training is due. If we do not complete it on time we are not allowed to work".

As well as core training, staff received specific training to support them in working with people who had complex health and support needs. We spoke with the registered nurse who carried out assessments for clinical support. They told us "Following an assessment I feedback to case managers. I recommend skills and learning needs for staff to support a particular person. We then look to match people up with staff who have the right skills. We will put staff on training to support them. For example, infection control training for barrier care". We noted that staff were assessed for competency in areas such as medicine administration, catheter care, moving and handling and tracheotomy care before carrying this out in practice.

Staff made positive comments about the training they received. Feedback included "I get all the training I need", "Training for care staff involved with complex care is quite good" and "I was provided with extra training to support one person I work with".

The deputy manager said that staff support was offered through annual appraisals in addition to one to one meetings or supervision. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. We saw records to confirm that supervision, observations and annual appraisals had taken place. This showed us that staff training needs were kept under review so that they

were aware of their roles and responsibilities and had the skills, knowledge and experience to support people who used the service.

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, 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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. For people in the community who needed help with making decisions an application should be made to the court of protection. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection no one who used the service was deprived of their liberty or under a court of protection order.

Care plans had been signed by the person or a representative to indicate they had given their consent. The care records we looked at showed that people's capacity to make decisions was considered. For example, one person who was PEG fed, preferred to have soup but this would normally be too thick for the tube. A risk assessment had been completed and signed by the person's advocate to say this was their preference and that the person was aware of the risks and gave their consent.

The registered manager told us staff received training about the Mental Capacity Act during their induction and this was confirmed by the staff we spoke with.

Some people had complex needs in relation to eating and drinking. There was clear guidance in care plans about the support people required in this area. The Speech and Language Team (SALT) were involved when required and we noted that individualised SALT guidelines were in place as needed. Staff had received training in how to support people where complex assistance was required, such as PEG feeding.

People were supported to maintain their health and had access to health services as needed. Support plans contained clear information about peoples' health needs. Many of the people who used the service had complex health needs and we saw that the service made good use of advice and support from other professionals. The service had good links with the local community nursing service, doctors and other health specialists. The branch nurse told us, "We have a good relationship with the local Clinical Commissioning Group (who fund some packages of support) and work well with others".

Good

Our findings

We received positive comments from people who used the service and their relatives about the care and support they received. These included, "Carers go the extra mile", "They [care staff] are very respectful of being in [Name's] home. Very good" and "They are very good at understanding [Name]". The staff we spoke with demonstrated a caring and person centred attitude to their work. One member of staff told us, "I try to make it the best I can for [Name]" and another said "We ask what people want and prefer. We make sure we are doing what the clients want".

People and their relatives told us they were treated with respect and dignity. This was an area that care staff told us was continually promoted within the organisation. One member of staff commented, "The main thing is promoting dignity and respect. This is a focus in all our training". Another member of staff explained, "I am very aware of respecting people's privacy and dignity. I had some training about how to assist [Name] getting in and out of a car. The training was all about doing it in a way which supported dignity and personal choice".

We looked at how the service promoted dignity and respect. The registered manager told us that this was discussed in induction for new staff as it was an important aspect of their work. Staff said that whatever training they had included the importance of dignity, respect and choice. People's care plans were also written in a way which emphasised respect and dignity whilst carrying out care tasks.

We noted that the staff handbook included a code of conduct for care staff which described how they must "Promote and uphold the privacy and dignity…of people" as well as "Uphold and promote equality, diversity and inclusion". There were also detailed policies in place regarding privacy, dignity and diversity in relation to people who used the service.

Care plans held clear information about how people wanted to be involved with their support as well as any choices and preferences they had communicated to the service. Because some people had complex needs they were unable to communicate effectively without support. Although people had relatives who could speak on their behalf, care staff told us that it was important for them to communicate directly with the people they were supporting. One member of staff described how they supported a person who could only communicate through eye movement. They had developed an alphabet communication board which enabled the person to spell out words, supporting them to be involved and to have a say. The staff member explained that they had researched ideas and had training in communication to support them.

People and relatives told us that they were involved in reviews and meetings where they could discuss progress and share concerns or new ideas. They confirmed that they could speak to someone at the office when needed and that there was an on call system for when the office was closed. Feedback confirmed that people felt listened to when contacting the office and that any issues were usually dealt with promptly.

Good

Our findings

Before people started to receive a service an assessment of their needs was carried out. We found that the initial assessment completed on individuals was based on information gathered from the person themselves or their representatives. Additional information was gained from the support plan provided by the local authority that commissioned the service (when they funded the care package or were involved in the person's care). The assessment included information about personal details, time/days of calls required, environment, next of kin and health professionals involved in the person's care.

Each person had individual care and support plans in place, which contained information about their needs and what support was required from care workers in order to meet those needs. Areas covered included managing risk, nutrition, mental capacity, medication and personal care. Records showed that each person's welfare was taken into account, including their physical health, mental health and emotional and personal relationships. Care records had been written using a person-centred approach. This meant they described the person's abilities and how they preferred their care needs to be met.

The service specialised in providing support to people with complex care needs and some people received support over 24 hours, seven days a week. Where people used specific equipment as part of their care, there was detailed guidance in place, such as the use of hoists or bedrails. Assistance was provided not only with personal care, but with daily living and social activities. Care records included details of how people preferred to be supported in their day to day lives in order to follow their own interests.

Care plans were up to date and reviewed as necessary. One relative told us, "Yes, we have reviews to check up on things". There was clear evidence that people and their relatives were closely involved in discussions about any changes in needs and how support should be changed to accommodate those needs.

We looked at how people were supported to make complaints if they needed. Records showed that when complaints were received by the office they were logged and an acknowledgement letter was sent out. An investigation took place which usually involved a meeting with the complainant. Following investigation a written response was sent out. The community matron reviewed complaints before they were closed to make sure that correct procedures had been followed. There was one recorded complaint so far this year which had been responded to in line with policy and procedure.

Although people were informed about how to complain when they started the service, there was no complaints leaflet which could be given to people in a format that they could understand. One relative told

us that when they asked for information on how to complain, they were told that a guide was not available. The relative added, "I raised this as an issue". We spoke with the registered manager about this who explained that they were aware this was an issue and that a complaints guide was currently being produced by the provider.

Requires Improvement

Our findings

The registered manager spoke knowledgeably about the service and had a clear understanding of the requirements of their role. They were passionate about their commitment to providing personalised care and support and said that this was a focus for the service. They explained, "I'm learning all the time. I am very passionate about it. I always do the 'mum's test' for the support we provide. I care very much".

We were told that the registered manager split their time between two office locations, and the deputy manager covered day to day management in their absence.

We looked at the management of notifications which the provider is required to send to the CQC. We identified four recorded incidents which had been raised with the local authority as safeguarding concerns but which had not been reported to the CQC. The failure to notify CQC of these concerns was a breach Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We have dealt with this matter separately with the provider.

Although there were systems in place to monitor areas of practice and assess quality, these were not always effective at making sure procedures were followed. We found a record of an internal governance monitoring visit in May 2016 which had considered the area of Well Led. This included a section about whether the service had notified the CQC in line with regulations. The issue of non-reporting of safeguarding concerns had not been identified. We raised this with the registered manager who admitted that this had been an error and assured us they would discuss this with the governance team. We have received all four notifications since this inspection.

We recommend the provider review quality monitoring systems to make sure they are robust and cover all aspects of service provision.

We looked further into how the provider monitored the quality of the service provided. There was a governance team based at Head Office who carried out a monitoring visit at the branch office every three months. This was carried out in line with the CQC domains of Safe, Effective, Caring, Responsive and Well Led. Records confirmed these visits took place. A report was produced after each visit which outlined the findings and any areas of practice which required improvement.

There were regular audits of practice which included a quarterly care plan audit and monthly medicine record check. Records showed that there were regular 'spot checks' of care staff when they were working

which covered areas such as diet, choice, independence and health and safety. The provider employed a community matron who was based at Head Office and who provided additional clinical oversight. We saw that the progress of each complex package of care was fed back to the community matron. This provided an additional check to make sure that people's needs were being suitably met.

The provider had a clear set of visions and values which were promoted in the staff team. These were detailed in the handbook which was provided to staff when they started work. The provider's vision was to "Redefine the future for people and places" and this was supported through a set of values which included "Everyone has a voice" and "Take pride in what you do". The provider had also made a commitment to the agenda for care and compassion led by the Chief Nursing Officer for England. This was driven by a set of six principles which included care, compassion and communication.

The provider carried out quarterly surveys of people who used the service, relatives and relevant professionals to seek their views about the care and support provided. Each survey focussed on a different area of practice such as caring, effective and well led. Care staff received a yearly questionnaire which gave them the opportunity to feedback their views. Survey returns were reviewed by the governance team at Head Office who fed back results to the registered manger, detailing any areas which required further action or improvement.