All Hallows Healthcare Trust

All Hallows Homecare - Lowestoft

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This service is a domiciliary care agency. It provides personal care to people living in their own homes. At the time of this announced comprehensive inspection of 15 & 19 March 2018, there were 45 people who used the service. We gave the service notice of our inspection to make sure that someone was available.

The location of All Hallows Homecare - Lowestoft was registered in October 2016 and this was their first inspection.

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.

There were systems in place designed to keep people safe from harm and abuse. Where incidents occurred these were learned from and used to drive improvement in the service. There were infection control processes and procedures in place to reduce the risks of cross infection. There were arrangements in place to provide people with their medicines safely, where they needed this support. There were safe recruitment systems in place and the service ensured there were enough staff to cover the required care visits.

People were cared for and supported by care workers who were trained and supported to meet their needs. Where required, people were provided with the support they needed to meet their dietary needs. People were supported to access health care professionals, where required, to maintain good health. The service worked with other professionals involved in people's care to provide an effective and consistent service. The service was working within the principles of the Mental Capacity Act 2005. People's consent was sought before any care was provided.

People told us that their care workers were respectful and caring. Care records guided care workers in how people's privacy, dignity and independence was promoted and respected. People were involved in making decisions about their care and support. People's views and preferences were valued and listened to about how their care was planned for and delivered.

People received care and support which was assessed, planned and delivered to meet their specific needs. There were systems in place to provide people with the care and support they wanted as they neared the end of their life. There was a complaint procedure in place and people knew how to raise a complaint about the service they were provided with.

There was an open and empowering culture in the service. People were asked for their views of the service and these were valued and acted on. There was a quality assurance system in place and shortfalls were addressed. As a result the quality of the service continued to improve.

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 were systems in place designed to reduce the risks to people and keep them safe from harm.

There were enough staff to meet people's needs. There were safe systems for recruiting staff.

Where people needed support to take their medicines this was done safely.

Systems to minimise the risks of cross infection were in place.

Is the service effective?

Good

The service was effective.

People were cared for by care workers who were trained and supported to meet their needs.

The service worked within the principles of the Mental Capacity Act 2015.

Where people required support with their dietary needs, this was provided. People had access to health professionals, where required.

The service worked with other professionals involved in people's care to provide a consistent service.

Is the service caring?

Good

The service was caring.

People were treated with kindness. Staff respected their privacy, independence and dignity.

People were involved in making decisions about their care and these were respected.

Is the service responsive?

Good

The service was responsive.

People's care was assessed, planned and delivered to meet their needs and preferences.

There were systems in place to support people who needed end of life care.

There was a complaints procedure in place and people knew how to make a complaint if needed.

Is the service well-led?

Good

The service was well-led.

The service provided an open culture. People were asked for their views about the service.

There was an effective quality assurance system in place. As a result the quality of the service continued to improve.

All Hallows Homecare - Lowestoft

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This announced comprehensive inspection was carried out by one inspector on 15 and 19 March 2018. We gave the service notice of the inspection visit because we needed to be sure that someone would be available to support the inspection.

The inspection site visit activity started on 15 March 2018 and ended 23 March 2018. On the first day of 15 March 2018, we visited the head office whilst we were inspecting the provider's other domiciliary care service. Because this service had the same provider, registered manager and deputy manager we reviewed some evidence relating to this service. The reports for both of the inspections will be the same as the other location in parts. We spoke with the registered manager, the deputy manager, the chief executive of the Trust, a registered nurse, the administrator and a member of the human resources staff, and two care workers. We reviewed two care worker's recruitment records and records relating to the management of the service, including audits and training records.

On 19 March 2018 we visited the location office and again met with the registered manager and deputy manager. We also spoke with the administrator, and five care workers. We reviewed eight people's care records and records relating to the management of the service.

On 23 March 2018 we spoke with seven people who used the service and four relatives on the telephone.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service

does well and improvements they plan to make. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

Prior to our inspection we sent questionnaires to 27 people using the service, 27 to relatives, 28 to staff and five to community professionals. This was to gain feedback about the service provided. We received completed questionnaires from 13 people, three from relatives, 15 from staff and one from a community professional.

Good

Is the service safe?

Our findings

People spoken with told us that they felt safe using the service. One person said, "They [care workers] make sure I feel safe. When they are helping me with a shower I feel safe." One person's relative commented, "If they [care workers] are ever worried about [family member] they will do something, call me or call the doctor. I know that [family member] is safe."

All of the questionnaires we received from people, relatives and a community professional said that they felt that people using the service were safe from abuse and or harm from their care workers. There were systems in place designed to minimise the risks to people in relation to avoidable harm and abuse, including policies and procedures. Care workers received training in safeguarding people from abuse and they understood their roles and responsibilities, including identifying possible abuse and how to report concerns.

All of the questionnaires from care workers said that they knew what to do if they suspected a person was being abused or was at risk of harm. We received feedback from a community professional in a questions which identified that the service had acted on a safeguarding concern. They stated, "They have acted on safeguarding concerns swiftly, including suspending a carer…" Discussions with the registered manager and records identified that where safeguarding incidents had happened, the registered manager took appropriate action to reduce future risks. This included disciplinary action. In addition where care workers had reported concerns about people's safety, the service's staff had referred these to the local authority safeguarding team, who are responsible for investigating safeguarding issues.

The provider had systems in place to learn from incidents and use them to improve the service provided. This included making referrals to health professionals and advising care workers on their roles and responsibilities. In all of the records of incidents there was a section where the registered manager had identified the lessons learned and what would be put in place to reduce future issues.

Care workers received guidance on how the risks in people's lives were assessed and minimised, in people's care records. These included risks associated with people's mobility, and risks that may arise in people's own homes. If people were at risk of developing pressure ulcers or had pressure ulcers, care records gave guidance to care workers about actions they should take to reduce risks. This included assisting the person to move position at each visit, the use of prescribed creams, equipment and when they should report concerns to a community nursing team for treatment. Risk assessments were updated and reviewed to ensure that any changes or emerging risks were included and up to date.

We received information from people in both the questionnaires about the timings of their care visits. One person in their questionnaire said, "Timing is a bit erratic." One community professional in their questionnaire stated, "Carers don't always turn up on time or stay the full allocated time due to pressure of workload." We discussed this with the registered manager and they told us that they had been working in this area to improve. We had received the questionnaires the last quarter of 2017 and we were assured that action was being taken.

People we spoke with told us that there had been no missed care visits. One person said, "They [care workers] turn up." People also said that they were usually told when their care workers were running late. However, one person said, "I'm not always told, I just call the office." Another person commented that their visits were never at the same time and sometimes their morning visit was too late. We fed back the concerns raised to the registered manager and they assured us this would be improved.

People were advised that care workers may be late by up to 15 minutes. If this was longer, people were called to advise and arrangements were made if their care workers were going to be very late for someone else to visit them, for example the office staff who were trained in care. Care workers were provided with travel time between visits to people. This supported them to arrive to their planned visits as near to the planned time as possible. People were provided with a rota if required which identified their visit times and the care worker who was planned to visit them.

There were systems in place to provide people with care workers to meet their assessed needs. The registered manager told us that there were sufficient numbers of care workers to ensure that people's care visits were completed as planned. They said that they were currently overstaffed and the extra hours were used as befriending visits to people who were alone. Care workers spoken with told us that they felt that there were enough care workers to cover all people's visits. One said, "If anyone goes off sick, we all pull together as a team and make sure people are visited."

Records and discussions with a human resource staff member showed that the service's recruitment procedures were in place to check that staff were of good character and were suitable to care for the people who used the service.

People told us that they were happy with the arrangements for the support they received with their medicines. One person commented, "They [care workers] just have to check I have taken them, I would forget."

Systems were in place to provide people with their medicines safely, where required. Care workers received training in medicines and competency checks were undertaken. People's records provided guidance to care workers on the level of support each person required to take their medicines. Medicines administration records (MAR) were appropriately completed, which identified that people were supported with their medicines as prescribed. There was a robust system for auditing MAR and the medicines provided to people. This system supported the management team to identify any issues and to take action to address them. The audit analysis identified any trends and actions taken included additional training, competency checks and/or supervision for care workers. An action plan was completed if trends were identified including if a person regularly refused their medicines, the service contacted the GP to seek advice. In addition, if there were specific medicines issues, these examples were used in the medicines training for all care workers. This meant that the service had systems to learn from incidents and use them to drive improvement.

All of the questionnaires from people and relatives said that the care workers did all they could to prevent and control infection, for example, by using hand gels, gloves and aprons. There were systems in place to reduce the risks of cross infection including policies and providing care workers with personal protection equipment, such as disposable gloves and aprons. Care workers were provided with training in infection control and food hygiene. Hand washing and the use of items including gloves and aprons, were included in the supported visits of care workers. These were observations by the management team of care workers' usual work practice.

Good

Is the service effective?

Our findings

People's care needs were assessed holistically. This included their physical, mental and social needs. The service's staff worked with other professionals involved in people's care to ensure that their needs were met in a consistent and effective way. This included when they moved from and to other services. For example, the service provided information to the hospital staff about people's care needs, if they required to be admitted to hospital. In addition the service worked with other professionals to provide end of life care to people using the service.

The registered manager told us how they worked with other professionals involved in people's care to support people to remain at home in line with their wishes. This included, with people's consent, referrals to occupational therapists to arrange assessments for equipment, which may make their lives more comfortable and safer. One community professional in their questionnaire said that they service's staff acted on any instructions and advice they gave.

People were supported to maintain good health and had access to health professionals, where required. One person told us, "If I am not feeling right, they [care workers] will talk to me about getting the doctor in." Health professionals, including doctors, were contacted with people's consent. When treatment or feedback had been received this was reflected in people's care records to ensure that other professional's guidance and advice was followed to meet people's needs in a consistent manner.

Where people required assistance, they were supported to eat and drink enough and maintain a balanced diet. Care records showed that people were supported to reduce the risks of them not eating or drinking enough. Care workers received training in nutrition and hydration. People's records included information to show that people were supported to meet their assessed needs and preferences. This included if people required a specific diet such as gluten free.

In the questionnaires from people, 84% said that the staff had the skills and knowledge to meet their needs. All of the questionnaires from relatives said that the care workers had the right skills and knowledge to care for their relative. One person we spoke with stated, "I do think they [care workers] are all trained."

All of the care workers we spoke with, told us that they were provided with training and support to meet people's needs effectively. One said, "If we have someone on our round with different needs, they get the training. They [management team] are in touch with [other professionals] who can help." They shared an example of how a person used equipment to eat and the care workers team received training in this.

Training included moving and handling, safeguarding, medicines and food hygiene. Care workers were provided with training in subjects on people's specific needs and conditions, such as dementia and diabetes. The registered manager told us that people with specific conditions were not taken on in the service until care workers had been trained to meet their needs appropriately. This included training on continence and eating equipment used by people. The registered nurse said that they had good relationships with other health professionals in the community and accessed training from these specialists

for care workers to meet people's needs effectively. They shared an example of a person who used equipment to assist them with their breathing and training was sourced from a respiratory nurse and how to support the person with their equipment. The registered nurse also provided training on specific subjects relating to people's health and wellbeing. This included certain medicines that people used. They had also developed 'frequently asked questions' information for care workers.

The questionnaires received from care workers said that they had an induction which prepared them fully for their role before they worked unsupervised. If newly recruited care workers had not yet achieved a recognised qualification, they were supported to complete the Care Certificate. This is a recognised set of standards that care workers should be working to.

Care workers were supported in their role and were provided with one to one supervisions. These provided care workers with the opportunity to discuss the way that they were working, receive feedback on their work practice and identify any training needs.

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.

All of the questionnaires from care workers said that they had training in and understood their responsibilities under the MCA. Care workers we spoke with told us that they had attended MCA training and they understood why it was important to gain people's consent before providing any care. Care workers sought people's consent before they provided care, and acted on their wishes. One person said, "They always ask me what I want them to do, even though it is my book [care plan], they ask anyway. I think that is good." People's care records identified their capacity to make decisions. Before we telephoned people, the care coordinator sought their consent.

Good

Is the service caring?

Our findings

People had positive relationships with the care workers who cared for and supported them. One person said about their care workers, "They are very much respectful." Another person said, "Respect absolutely, to be honest on all counts, dignity, privacy, they [care workers] are all very good." Another person commented, "They [care workers] are all respectful and kind. Not a bad word said at all." People's relatives told us about how the care workers were caring with their family members. One person's relative said, "[Family member] tells me they get on well with the carers. When I have been there the carers have always been polite and have a chat with [family member]."

All of the questionnaires from relatives and a community professional said that the care workers were caring and kind, 92% of the questionnaires received from people agreed with this. All of the questionnaires from people, relatives and a community professional said that the care workers always treated people with respect and dignity. One community professional stated in their questionnaire, "The positive feedback is that the carers are friendly, supportive and respectful."

All of the staff we spoke with knew people well and spoke about them in a caring and compassionate manner.

We asked people, in our questionnaire, if they felt that they were supported to be as independent as they could be, 92% said that they were. All of the questionnaires from relatives, care workers and a community professional said that people were supported with their independence. People we spoke with told us that they felt that their independence was promoted and respected. One person said, "I am keeping my independence, I can look after all my medication. They [care workers] make sure I am still managing. I like that. They don't treat me like a baby."

People's care records included information for care workers about how people's choices, privacy, dignity and independence should be promoted and respected. One person said, "They [care workers] are very good about my privacy, they help me to get a shower, make sure I am not embarrassed." Another person said, "They [care workers] get a towel and cover me up." One person's relative commented, "[Family member] wants to stay at home, with [their] own stuff. It's a little piece of independence and they [care workers] help to keep this."

People told us that they felt that their views and comments were listened to and acted on. One person said, "They [care workers] do listen to me. They always ask what has gone on and if I am okay." We asked people in our questionnaire if they were involved in the decision making about their care needs and 85% said that they were.

People's preferences, including what was important to them, how they wanted to be addressed and cared for was included in their care records. In addition reviews were completed with people using the service to discuss if they were satisfied with the care received. This showed that people's views and preferences were valued and used to assess, plan for and meet their needs. There was information about people and their

history, which supported the care workers to know about them, their history and interests. The care records also included people's goals, for example, one person's records said, "Not to be isolated."

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. One person said, "I am more than happy with everything. It [the care provided] is near perfect." All of the questionnaires from relatives said that they were happy with the service provided and 92% of people said that they were happy with their care.

When people started to use the service, a senior team member assessed their care needs. These assessments then informed the care plans which identified how people's needs were to be met. People's care records were person centred and included detailed care plans which provided care workers with guidance on people's assessed needs and preferences and how these were met. This included people's diverse needs, such as specific conditions, and how they affected their daily living.
People's care plans advised care workers to ask how people were at each visit. Daily notes included the care that had been provided and how the person presented, including, "Had a lovely chat."

Where people were at the end of their life the service provided the care and support that they wanted. People's wishes, such as if they wanted to be resuscitated and where they wanted to be cared for at the end of their life, were included in their care records. The registered nurse and deputy manager, who was also a registered nurse, were responsible for working with the continuing care team. This included working with other professionals to support people to remain in their home, in line with their choices, at the end of their life. The deputy manager and registered nurse told us how people were supported at the end of their life, including working with professionals to ensure people were provided with a pain free and comfortable end of life care. The registered nurse told us that they had a background in palliative care and incorporated their learning and experience into the training and care planning for people who received end of life support and care. This included the Gold Standards Framework (GSF) which is a recognised standard of end of life care, advanced care planning, how to speak with people about their end of life choices, and support to families including signposting them to other organisations. The registered manager told us that a member of the staff team always attended a person's funeral. In addition if people were in hospital the care workers visited them.

We spoke with care workers about end of life care. They told us that they had been provided with training and care workers who were confident and able supported people with their end of life care. They said that they recognised that this was an important [part of their work, which they were proud of. One care worker told us about the care they had provided to people at the end of their lives, "It is about giving people dignity in their last days. I like it, knowing you have played a part in their wishes."

People's relatives were asked to complete a survey by the service to show that they were satisfied with the care and support their relative had received at the end of their life. This was used to further improve the service, where required. We saw a survey which had recently been completed. The survey asked what went well and the relative had written that their family member had, "Died in own home, dressed and hair combed…" the survey also asked if anything could have been done better, the relative had written, "Nothing."

The registered manager told us how the service had responded to provide care to people who needed it during the recent poor weather, which affected travel. People's care needs were rated, included if people lived alone or with relatives. Some people who lived with others were advised that care workers were not able to get to them, and some had cancelled their visits themselves.

People we spoke with knew how to make a complaint and felt that they were listened to. One person said, "I have never done a written complaint. But I would do it if I needed to. I know they would do something, I once mentioned I did not want [a care worker] to come to me. They [management] asked why, I just didn't get on with them, and I never saw them again." One person's relative told us, "In the beginning there were a few little issues, when I told them it was acted on straight away." The questionnaires received from people showed that 85% said that they knew how to make a complaint. However, we saw that Information about how people could complain about the service they received was provided to people in their care folder when they started to use the service.

There was a complaints procedure in place, which advised people and others about how their concerns and complaints would be addressed. There had been no formal complaints about the service in the last 12 months. The registered manager showed us records of concerns received which had been addressed promptly and used to drive improvement in the service. For example, one person had told a member of the management team they did not want to complaint but preferred a change in care worker, which was done. In a questionnaire that we received there were concerns raised about the service. We asked the registered manager to look into this. They investigated and responded fully to this in line with their complaints procedure.

Good

Is the service well-led?

Our findings

This location had been registered with the Care Quality Commission (CQC) in October 2016. There was a registered manager in post. A registered manager is a person who has registered with CQC 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 registered manager understood their roles and responsibilities in providing a good service to people. They told us how they kept updated with changes in the care industry. They had worked with an organisation who undertook a 'mock' inspection of the service. They had attended a registered manager's conference where they shared examples of good practice. The registered manager also attended training that care workers were provided with, for example the recent training from a specialist respiratory nurse.

The registered manager and provider worked to deliver good quality care to people. There were quality assurance systems in place, which enabled the provider to identify and address shortfalls. These included checks on medicines management, training, care records and incidents and accidents. There was a robust system in place to audit people's care records to ensure they were in line with people's planned care. If shortfalls or trends were identified in the analysis of the audits, an action plan identified how action was taken to address them, including speaking with care workers in team meetings or supervision. The provider information return (PIR), completed by the registered manager, identified what the service were doing and where they had planned improvements.

There were systems in place to monitor the standard of care that care workers delivered. Care workers were observed by the management team in their usual work practice. The management team referred to these as supported visits. These checked that care workers were working to the required standard and providing people with a good quality service. There was a system in place to monitor care worker's practice. If there were shortfalls identified in the support visits, care workers were advised, further support visits were planned, if improvements had not been made this was then discussed in supervision and another support visit was planned.

The Trust's chief executive told us how they ensured all of the provider's services continued to improve. To support this there had been a restructure in the provider's senior management. There was regular communication between locations to share good practice, suggestions for improvement and using learning from all locations to drive improvement. There was a structured system in decision making which included senior management and the management teams from each location. We saw the minutes from the core management meetings, which confirmed what we had been told.

There was a system to continually improve the culture across the organisation, including the introduction of values workshops from January 2018. Each member of the organisation was to attend. These were to ensure a caring and compassionate organisation. We spoke with care workers who told us that they had attended this training and felt that it clearly explained the values that they should demonstrate. They were also

sharing learning via newsletters, which were provided to staff working in the Trust with their pay slips. Changes had been made in the provider's terms and conditions for its staff; staff were kept updated in meetings and information provided. Since July 2017, there was a clinical educator in place who was a registered nurse, they were working on the provider's mandatory training, development and induction. From April 2018, improvements were being made in the appraisal system, based on the values workshop to improve on quality and efficiency. All of the improvements made were seen as a way of improving the service provided to people.

A log of missed visits were maintained which clearly identified the reasons why this had happened, people were provided with a replacement care worker if needed and an apology. There had been six missed visits since June 2017. The missed visit log identified how lessons were learned from these and actions taken going forward to reduce the risks of them happening again. This included for example, speaking with care workers and advising them of checking for any changes in their roster, such as if it had changed because of short notice leave of colleagues.

There was an open culture in the service where people's comments were valued. The service listened to and valued people's comments and used them to improve the service. This included in annual satisfaction surveys. We saw the results from these surveys from 2017. The registered manager told us how they addressed people's comments when areas for improvement had been identified. This included reviewing and updating people's care plans and advising care workers of the ways they should be working. There were action plans and analysis in place to evidence what we had been told.

One care worker in their questionnaire stated, "I like the company and feel that each individual's needs (including care staff) are met fully." Another said, "I have never felt as supported as I do now. I am proud to tell people that I work for All Hallows delivering a very high level of care which is at the very core of what the organisation stands for." All of the care workers spoken with were complimentary about the service and how it was led. One care worker said, "I feel very supported, there is always someone on the end of the phone if you need help or advice." Another said, "Management are good, approachable. We have good team work here." One community professional in their questionnaire stated, "Management at All Hallows are approachable and helpful."

There was a system in place to show that the care and support provided by care workers was valued. These were called 'Precious Moments' where the service had received feedback of care workers 'going over and above' from people using the service, relatives or colleagues. Staff meeting minutes showed that Precious Moments were discussed. The minutes from the meetings also identified that care workers talked about the new terms and conditions, training courses including palliative care and values and the medicines administration records (MAR) audits were discussed.

The deputy manager told us how the service had an empowering culture for the staff who worked there. This included meetings for team leaders where they were asked to set their own agenda. The meetings were attended by team leaders from both of the provider's domiciliary care services. This ensured that learning and good practice was shared across the services. The minutes from a meeting in February 2018 identified that the team leaders discussed how people's needs were met and all risk assessments and care plans were in place.