DCS&D Limited

DCS and D Limited T/A Heritage Healthcare Guisborough

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

The inspection took place on the 8 August 2016 and was announced. The provider was given notice because the location provides domiciliary care services and we need to be sure that someone would be in. A second day of inspection took place on 1 September 2016 and was announced.

DCS and D Limited T/A Heritage Healthcare Guisborough is a domiciliary care service which provides personal care to people within their own homes. It is based in Guisborough and provides care and support to people in Redcar and East Cleveland. At the time of inspection 104 people used the service.

The service had a registered manager. 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 and processes in place to protect people from the risk of harm. Staff were able to tell us about the different types of abuse and what actions they would take if they suspected abuse was taking place. Safeguarding alerts had been made when needed.

Risk assessments were in place for people who needed them and were specific to people's needs. Risk assessments had been regularly reviewed and updated when required.

Robust recruitment procedures were in place and appropriate checks had been made before employment commenced.

The registered provider had policies and procedures in place to ensure medicines were managed safely. Accurate records were kept to show when medicines had been administered.

Staff performance was monitored and recorded through a system of regular supervisions and appraisals. Staff had received up to date training to support them to carry out their roles safely and had completed an induction process with the registered provider.

People were supported to maintain their health through access to regular food and drink. Appropriate tools were in place to monitor people's weight and nutritional health. Staff knew how to make referrals to health professionals should anyone using the service become at risk of malnutrition.

Staff demonstrated good knowledge and understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Documentation was available for those people who had Court of Protection orders in place.

Where appropriate, staff supported people to enjoy a good diet and suitable food and nutrition. People

were supported to maintain good health and had access to healthcare professionals and services when needed. People made regular visits to their own GP.

People and relatives were actively involved in care planning and decision making, which was evident in signed care plans. Information on advocacy services was available.

Relatives spoke highly of the service and the staff. People said they were treated with dignity and respect.

Care plans detailed people's needs, wishes and preferences and were person centred which meant people received personalised support. Care plans had been reviewed and updated regularly.

The registered provider had a clear procedure for handling complaints which we could see had been followed.

Staff described a positive culture that focused on the people using the service. They felt supported by the management. Staff told us that all managers were approachable and they felt confident that they would deal with any issues raised.

Staff were kept informed about the operation of the service through regular staff meetings. Staff were given the opportunity to recognise and suggest areas for improvement.

Quality assurance systems were in place and completed by the registered manager. Senior management also visited the service regularly to monitor the quality of the service.

Accidents and incidents were monitored to identify any patterns and appropriate actions were taken to reduce the risks.

The registered manager understood their role and responsibilities. Notifications had been submitted to CQC in a timely manner. Notifications are changes, events or incidents the registered provider is legally obliged to send us within the required timescales.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risk assessments were in place for people who needed them and were specific to people's needs.

There were systems and processes in place to protect people from the risk of harm. Safeguarding alerts had been raised when required.

A safe recruitment procedure was followed to reduce the risk of unsuitable staff being employed.

Medicines were managed appropriately. The registered provider had policies and procedures in place to ensure that medicines were handled safely.

Is the service effective?

Good

The service was effective.

Staff performance was monitored and recorded through a regular system of supervision and appraisal.

Staff had received training to support them to carry out their roles safely.

Staff demonstrated good knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were supported to maintain their health.

Is the service caring?

Good

The service was caring

People spoke highly of the staff and said they were treated with respect.

Staff were knowledgeable about the likes, dislikes and preferences of people who used the service.

Care and support was individualised to meet people's needs.

Is the service responsive?

Good

The service was responsive.

People, and where appropriate their relatives, were actively involved in care planning and decision making.

Care plans were detailed, personalised and focused on the individual's care needs.

The registered provider had a clear process for handling complaints. People we spoke with confirmed they knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

Quality assurance processes were in place and regularly carried out to monitor the quality of the service.

Feedback from people who used the service and staff was sought.

Regular staff meetings had taken place and staff told us they were supported and included in the service.

The registered manager understood their responsibilities in making notifications to the Care Quality Commission.

DCS and D Limited T/A Heritage Healthcare Guisborough

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 8 August 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 at the registered location.

The inspection team consisted of one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also requested feedback from local authorities that contracted services with DCS and D Limited T/A Heritage Healthcare Guisborough. We reviewed information from people who had contacted CQC to make their views known about the service.

During the inspection we spoke with eight people who used the service and seven relatives. We looked at four care plans, ten Medicine Administration Records (MARs) and visit report sheets completed by staff. We spoke with five members of staff including the registered manager. We looked at six staff files which included training and recruitment records.

Good

Is the service safe?

Our findings

People told us they felt safe using the service. One person said, "We've been with them for four years and now both the carers and the provider seem part of the family – and yes of course we feel safe with them." Another said, "Yes I feel safe – my carers are regular and reliable in all matters." A relative we spoke with told us, "100% safe with this provider and the carers. We have had them for almost 3 years now. It's the first time we have had a provider that really cares and [relative] loves the carers!"

We looked at the arrangements for managing risks to ensure people were protected from harm. Risk to people were assessed and care plans put in place to reduce the possibility of them occurring. Where a risk was identified, further assessment took place to assist in taking remedial action. For example, a risk assessment that we looked at identified that a person was at risk of choking if meals were given to them orally. Percutaneous endoscopic gastrostomy (PEG) is a medical procedure in which a tube (PEG tube) is passed into a person's stomach through the abdominal wall. Most commonly it provides a means of feeding when oral intake is not adequate. As a result of this a care plan had been developed around the PEG which detailed how the care should be provided including the feeding routine. Another person was at risk of falls due to poor mobility. As a result a moving and handling care plan had been produced, which detailed how staff should transfer the person safely. We could see that risk assessments had been reviewed and updated regularly to ensure they met people's current needs.

We looked at arrangement in place for managing accidents and incidents and what actions were taken to prevent the risk of re-occurrence. Records were in place to show that accidents and incidents were reviewed on a monthly basis by management who checked to see if there had been any repeated patterns of accidents and incidents. Appropriate forms were completed for each accident or incident that had occurred. Blank accident and incident forms were also available in people's care plans so staff had access when they needed them, if accidents occured. We spoke to the registered manager who was able to tell us what action they would take if any person experienced regular accidents, for example making referrals to other professionals such as the falls team.

All staff spoken with had a good level of knowledge and understanding of safeguarding and the different types of abuse. They were able to tell us the procedure they would follow should they suspect abuse. An up to date safeguarding policy was available. We looked at the staff training records in relation to safeguarding. We could see that all staff had received training in safeguarding.

We looked at records relating to safeguarding. We could see that referrals had been made to the local authority when required and this had been recorded appropriately. The registered manager told us that the local authority requested that they complete a monthly 'consideration log' of safeguarding incidents that had been managed appropriately by the provider, without the need for a safeguarding alert being made to the local authority. We could see that these incidents had been appropriately recorded and submitted to the local authority in a timely manner.

Staff told us they would not hesitate to whistle-blow (tell someone) regarding any concerns they had. One

staff member said, "I would do what I had to do. I know the manager would be supportive and it is my job to keep people safe."

Systems were in place for the safe management of medicines. A medication policy gave guidance to staff on their roles and responsibilities for managing medicines safely, on handling 'as and when required' medicines and on reporting concerns. Each person's care file contained a list of their medication and the level of support they needed to administer them, and these ranged from self-medicating to staff administering them. People's use of medicines was recorded using a medicine administration record (MARs). A MAR is a document showing details of the medicines a person has been prescribed and records when they have been administered to them.

We looked at six people's MARs and saw there were no gaps in administration. Where medicines had not been administered the reason for this had been recorded. However, two of the MAR's that we looked at contained codes to indicate that medicines had not been given because the person had refused it, but this had not been recorded appropriately. We spoke to the manager about this who told us that this was an issue that had been addressed previously. We looked at the monthly MAR audits completed by office staff in July 2016 and could see that action had been taken to address the issue. The registered manager told us that they would expect to see an improvement when the MAR's audit in August was completed.

People we spoke with told us they were supported by a regular team of staff and were kept informed about any changes that needed to be made to the staffing arrangements. One person said, "I have my own team of carers who know me well. My rota is pretty much the same every week." Another person told us, "We might get someone else if the regular carer is on holiday but we are always told in advance." We asked the registered manager how they determined staffing levels. They told us that they constantly recruited new staff and only accepted new care packages if they were sure they had capacity to manage them appropriately. The registered manager told us, "Myself and the co-ordinators are very familiar with the staff and who is available to do additional hours if needed, for example to cover sickness and holidays. Generally if a carer leaves the service we will look to replace the staff member as soon as possible, but we always have an 'over-flow' to ensure we have enough staff." This meant that the service had procedures in place to ensure there was enough staff to appropriately support people.

During the inspection we looked at four staff recruitment files. We could see from the records we looked at that safe recruitment procedures were followed. Applications and interviews had been completed. Two checked references, where possible, from a current-employer - and a Disclosure and Barring Service (DBS) check had been sought prior to staff starting employment. The Disclosure and Barring Service carry out criminal records and barring checks on individuals who intend to work with vulnerable adults. This helps employers made safer recruitment decisions and also minimise the risk of unsuitable people working with vulnerable adults. Recruitment files also contained photographic identification and proof of identity.

Good

Is the service effective?

Our findings

We asked staff to tell us about their induction, training and development opportunities they had been given at the service. Staff told us, "I did a full week of training before I went out into the community with another staff member. I was asked if I felt ready and I think they assessed me to make sure I was ready. I've always had support." Another staff member told us, "We are regularly asked to attend training, sometimes to refresh but sometimes it might be a new course. We have the opportunity to do NVQ's as well".

We spoke to the registered manager about training who told us, "We use head office as a base for training. Inductions and training sessions run continuously so if we identify any gaps in training, plans can be put in place for this to be corrected within a short time frame, usually within a couple of weeks."

We looked at a training matrix which confirmed that mandatory training for staff was up to date. Mandatory training included safeguarding, moving and handling, infection control, first aid and medication. Mandatory training is training the registered provider thinks is necessary to support people safely. Training in specialist areas had also been provided to a large number of staff in areas which included PEG feeding, epilepsy and STOMA care. We looked at six staff files and could see certificates for training that had been completed. However, training in Mental Capacity was not up to date with only 10% of staff having completed it.

New staff had completed induction training before they worked alone. When staff had completed induction training they had a 'probation review' meeting with the registered manager to assess whether further training was needed and whether they wished to receive extra support in any areas. This meant that new staff received the support and training they needed to effectively support people.

People we spoke with told us they thought staff were suitably trained to look after them. One person said, "I can find no faults with them, they all know what they are doing" and "I know they all get training, I don't have any grumbles about them."

Staff were supported with regular supervision and appraisal. Supervision is a process, usually a meeting, by which an organisation providers guidance and support to staff. From the records we looked at, we could see that these meetings were used to discuss and provide support for needs that staff members had, as well as confirming their knowledge and performance over a period of time. Records confirmed regular supervisions and appraisals were taking place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 capacity to make particular decisions, any made on their behalf must be in their best interests and 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS), but these do not apply to people living in their own homes.

We checked whether the registered provider was working within the principles of the Mental Capacity Act 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Some of the people who were being supported were subject to a Court of Protection order. When a Court of Protection order was in place the registered provider had gained copies of the relevant documents to ensure they were providing the appropriate care and support. The registered manager had good knowledge of all the people who used the service who were subject to such orders. The registered manager told us they had contact details of an officer at the Court of Protection who they contacted should they need any advice.

The staff we spoke with had a good understanding of the principles of the Mental Capacity Act 2005 and were able to explain what action they would take if they suspected a person lacked capacity. One staff member told us, "I have done training on MCA and I would discuss anything with my manager if I was concerned about a person's capacity."

From the records we looked at we could see that training in Mental Capacity had not been completed by all staff. However, the registered manager told us about, and was able to show us, plans that were in place to ensure all staff had training in this area.

Care plans recorded peoples consent to support and details of any assessments that had been undertaken. We could see consent to care had been given by people or, where appropriate, their relatives, and signed documentation was present in care plans to evidence this. These documents covered areas such as consent to care and treatment, sharing information, key holding and medication being administered to people.

Some people received support with food and nutrition as part of their care package. One person said, "They do help me prepare food and snacks. I always choose what I want". Staff were able to describe how they worked with others to support people in this area. For example, one person was fed using a PEG. Information in care records detailed that the person's relatives took responsibility for the feeds but staff offered support in this area when needed. A detailed plan of the required feeds was available in the care plan and recorded on the person's MAR. Another person was at risk of malnutrition so 'food and fluid charts' had been implemented. From the food and fluid charts we looked at we could see that staff had accurately recorded any food or fluid that had been given on each visit.

The registered manager was able to tell us who they would contact if they had concerns regarding nutrition, such as a dietician or SALT. Care plans contained details of people's dietary preferences and any specific dietary needs they had, for example, whether they were diabetic or had any allergies. We looked at people's 'daily visit reports' which staff completed after each visit. This detailed what a person had chosen to eat and we could see that a variety of food was prepared and offered to people. This meant people were supported with food and nutrition where necessary.

Care records contained evidence of close working relationships with other professionals to maintain and promote people's health. These included GP's, district nurses, social workers and dieticians. We could see that referrals to these professionals had been made in a timely manner and these visits were recorded in people's 'daily visit reports'.

Good

Is the service caring?

Our findings

People who used the service told us they were happy and staff were caring. One person said, "I couldn't wish for better people to care for me". Another person told us, "I am grateful for all that the staff do. If it wasn't for them I don't know what I would do". A relative told us, "The company is absolutely brilliant. I couldn't wish for better."

Staff were able to explain to us how they respected a person's privacy and dignity, by keeping curtains and doors closed when assisting people with personal care and by respecting people's choice and the decisions they made. One staff member told us, "I never just walk into a person's home. I always knock, wait a second and then open the door and announce who I am. I always wait for them to say come in before I go any further." A relative told us, "Staff always treat [relative] respectfully when helping with showering and other personal tasks. I couldn't ask for more for my [relative]".

Care plans detailed communication techniques that were specific to the people that staff supported. For example, one care plan detailed how the person had limited verbal communication and would use their eyes to communicate and that staff should ensure they were sat at eye level before attempting to communicate with the person. The care plan also detailed words or sounds the person would make which meant 'yes' and that silence to a question meant 'no'. We looked at the rota for this person which showed that a regular team of staff who had an understanding of their communication needs supported them.

Care plans detailed people's preferences around the care and treatment that was provided. We could see evidence, such as signatures, that relatives had been involved in care planning and in some situations relatives had created a list of likes and dislikes which was available for staff to read. We saw evidence in care plans that relatives were regularly invited to care plan review meetings. Relatives we spoke with confirmed they were involved in their relatives care and kept updated.

It was evident from discussions with the registered manager that staff knew people well, including their personal history, preferences and likes and dislikes. People were able to choose a time for staff to visit and the registered manager told us they tried to accommodate everyone's preferences. We could see when people had requested a change in the time of a visit that this had been accommodated.

At the time of inspection no-one using the service was using an advocate. Advocates help to ensure that people's views and preferences are heard. The registered manager told us that they could be arranged for people who wished to have one, and was able to explain how this would be done.

Good

Is the service responsive?

Our findings

During the inspection we looked at four care plans. Care plans contained details of what was important to the person and how they wished to be supported. For example, there was a completed document which detailed the person's likes and dislikes, communication needs, and how they wished to be supported in areas such as personal care, medication and nutrition. An 'about me' document had also been completed. This contained details such as previous addresses, occupations and holiday destinations, a family tree and preferences around clothing and hair styles.

Care plans were person-centred and produced to meet individuals' support needs in areas such as personal care, communication, mobility, nutrition and sociability. They were detailed and focused on people's preferences and were reviewed on a regular basis. The care plans that we looked at were all up to date and were person centred. For example, one care plan detailed how feeding with support was needed and that food had to be cut into small pieces and placed at the side of the person's mouth. However, another care plan we looked at explained how the person can become 'anxious and required staff to reassure them' but it did not provide sufficient detail as to what could cause the person to become anxious or how they should be reassured. We spoke to the registered manager about this who told us that this person has a regular team of staff who were aware of the person's needs and how to respond when reassurance was required. They explained they would ensure this information was added to the care plan.

We spoke to the registered manager about how they ensure they can meet a person's needs before a new care package commences. The registered manager told us, "It is usually a social worker that will contact the office and speak to the care coordinators or myself. We will ask questions such as what the care package entails, specific times of calls and the needs of the service user. We then check our rota system to make sure we have staff available who can meet their needs before we would accept the care package."

We spoke with staff who were extremely knowledgeable about the care that people received. They told us that they had a regular rota and visited the same people on a daily basis. They were able to give details of how they delivered personalised care. One staff member told us, "We build relationships with people. When you visit them every day you know what they like and what they don't." Another staff member told us, "Care plans have enough detail in to guide you but generally you know the needs of the person before you visit. People don't like to have strangers."

People who used the service told us that staff were familiar with their likes and dislikes and their care needs. One person said, "They all know what they are doing. They know me and I know them." A relative we spoke with told us, "All the carers know [relative] very well. They know what [relative] likes and what [relative] doesn't like. Even the office staff know [relative's] needs which is comforting to know."

Some of the people who used the service were supported by staff to access the community and participate in activities. When this was required, as part of the care package, an activity diary was available in the person's home for staff to record each day what activities had taken place. We looked at these records and could see people were supported to enjoy a wide range of activities of their choice including baking,

shopping, creating scrap books, gardening and walks in the community.

The registered provider had a complaints policy which people who used the service received in their 'customer guide'. This explained how complaints would be investigated, with relevant timescales explained. There had been six complaints made to the registered provider in the past 12 months. These had been investigated in line with the registered provider's policy and we could see appropriate action had been taken by the registered manager. For example, one person was not happy as staff 'were not completing all tasks as expected'. As a result the registered manager had arranged a staff meeting with all staff to discuss these concerns.

The registered provider had three recorded compliments in the past 12 months. One said, "I am very impressed with the kindness when we required extra support and care to look after [relative]." Another said, "[Name] is a fantastic carer and brilliant with mum" and "they are all lovely girls, they are worth their weight in gold. I am very lucky indeed." These compliments were shared with staff at staff meetings.

Good

Is the service well-led?

Our findings

People who used the service spoke positively about the registered manager. One person told us, "The manager is very good. [Registered manager] has visited me and made me feel very confident about the care and staff. I can't see me ever wanting to go to another provider." Another person told us, "The manager is great. Always at the end of the phone and will come out willingly if we ask. Nothing is too much trouble."

During our inspection we could see that the registered manager had an active role in the day to day running of the service, often receiving telephone calls from people who used the service and staff seeking advice. The registered manager said, "I like nothing better than putting my uniform on and providing care, working with the staff in the community. I enjoy seeing people and speaking to them face to face. I don't want them to just think of me as 'the boss' in the office. I always have my office door open so I know exactly what is going on." It was clear that the manager was knowledgeable about people who used the service and their care needs.

We asked staff about the management of the service. Staff said there was a positive culture at the service and that they were supported by the registered manager. One staff member told us, "The manager is available whenever we need support or advice, I can't fault her." Another staff member told us, "I have always had support. {Registered manager] is always around and their door is always open."

Regular staff meetings had taken place with the most recent being in March 2016. The minutes of the meeting showed that staff had the opportunity to raise concerns and be involved in decisions about the service. Areas that were discussed included confidentiality, care plans, targets and safeguarding. The registered manager told us that they aimed to have three staff meetings annually where different topics would be discussed. We could see that these arranged meeting had been well attended by care staff.

During the inspection, we looked at feedback that was sought from staff and people who used the service. Questionnaires had been distributed in October 2015. The questionnaires asked people to provide feedback in areas such as care provided, staffing and quality of the service. The results were analysed and where issues were identified an action plan was developed. The registered manager told us that they used 'service user contact forms' and these were completed when contact was made with a person if they had raised a concern on a questionnaire. They also explained that no 'contact forms' had been completed for 2015 as the concerns raised in questionnaires were anonymous.

Staff questionnaires had also distributed. Only four had been returned in 2015, but contained all positive feedback.

People and their relatives told us they were regularly asked for feedback about the service and the care they received. One person told us, "We always get asked if we are happy or have any concerns – especially by the manager. We do get questionnaires to fill in." Another person told us, "I have had questionnaires but I don't think I have actually filled them in – if I have anything to say I will tell the staff or ring the office."

The registered manager carried out a number of quality assurance checks to monitor and improve the standards of the service. Quality assurance and governance processes are systems that help the registered provider to assess the safety and quality of their services, ensuring they provide people with good services and meet the appropriate quality standards and legal obligations. Monthly audits were carried out in areas such as care plans, MARs and daily visit reports. Where issues were identified, action plans were put in place to address them. For example, it was identified on one monthly MAR audit that staff had not been using 'codes' to record why medication had not been administered. An action plan was created and staff were contacted to discuss the concerns. This was also discussed in staff meetings.

The registered manager understood their role and responsibilities. We noted that all relevant notification relating to the service had been submitted to the Care Quality Commission.