Sanctuary Home Care Limited

Sanctuary Home Care Ltd - March

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

Sanctuary Home Care Ltd – March provides personal care to mainly older people living on-site. Communal and dining facilities are provided. Each person's flat is provided with kitchen, lounge and an en suite shower. There are communal bathing and toilet facilities. At the time of our inspection 23 people were using the service.

This comprehensive inspection was unannounced. It was carried out by one inspector on 15 November 2016.

The provider is required, as part of their registration, to have a registered manager. A registered manager was in post at the time of our visit. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage a registered service. 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.

People were kept safe because staff were knowledgeable about reporting any incident of harm. There were enough staff to support people with their individual needs. Pre-employment checks were completed so that only suitable staff looked after people who used the service. People were supported to take their medicines as prescribed.

People were helped to eat and drink sufficient amounts of food and drink. People were able to choose where they wanted to have their meals. A main lunch time meal was provided on-site for those people who chose not to cook for them self. People were supported to access health care services, if they were unable to do this to maintain their individual health conditions. The nature of the care promoted people's well-being by reducing the risk of social isolation.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. At the time of our inspection no person was assessed to lack capacity. Staff members had an understanding of the application of the MCA. Staff were aware of the actions to take if a person required a DoLS application to be made and had clear policy guidance about this legislation.

People benefited from being looked after by staff, who were trained and supported to do their job.

Staff looked after people in a kind and caring way. People and their relatives were involved in the review of their or family members' individual care plans.

People's individual health and social care needs were met. Staff had access to up-to-date records to provide people with the care that met their individual needs. People were able to make friends with each other. There was a process in place so that people's concerns and complaints were listened to and these were

acted upon.

There were management arrangements in place which supported care staff to look after people safely. Staff were made aware of their roles and responsibilities to provide people with safe and quality care. Staff and people who used the service were able to make suggestions and actions were taken, if these were needed.

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.

Staff were trained and informed about how to recognise any signs of harm and also how to respond to any concerns appropriately.

There were sufficient numbers of staff available to meet people's needs.

Risk assessments were in place to ensure that people were cared for as safely as possible and that any risks were identified and minimised.

Medicines were stored securely and were administered as prescribed.

Is the service effective?

Good

The service was effective.

The provider was acting in accordance with the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were looked after by staff who were trained and supported to do their job.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by kind and caring staff.

People's rights to choice, privacy, dignity, respect and independence were valued.

There were arrangements in place to ensure that people were enabled to make day-to-day decisions about their care.

Is the service responsive?

Good

The service was responsive.

People's individual health and social care needs were met. The support provided by the care staff enabled people to remain living independently in their own flat.

Staff had up-to-date written guidance to enable them to appropriately and safely meet people's individual needs.

There was a procedure in place which listened to people's concerns and complaints which were dealt with to the satisfaction of the complainant.

Is the service well-led?

Good

There was an open and transparent leadership culture within the management of the service.

People and staff were enabled to make suggestions and comments. As a result the provider took action to improve upon the quality of the service, in the event that this was an identified need.

Quality assurance systems were in place to ensure that people received the care that they needed.

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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 unannounced comprehensive inspection was carried out by one inspector on 15 November 2016.

Before the inspection we looked at information that we held about the service including notifications. Notifications are information regarding important events that happen in the service that the provider is required to notify us about by law.

The provider completed a provider information return (PIR) and sent this to us before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we received six out of 16 surveys we sent to people who used the service and one out of two surveys to community professionals. Although we sent out sixteen surveys to people's friends/relatives, unfortunately we received none.

We spoke with three people using the service; the head of care; one team leader; one chef manager and two members of care staff.

We looked at four people's care records. We also looked at other documentation which included audits; minutes of staff meetings; records in relation to the management of staff; compliments and policies.

Good

Is the service safe?

Our findings

All of the surveyed respondents said that people were kept safe from harm. During the inspection people told us they felt safe. One person attributed this to the security of the building. Another person said that they felt safe because of how staff looked after them. All of the people described the staff as being "good."

We checked and found that arrangements were in place to keep people safe. Staff were aware of their roles and responsibilities in keeping people safe from the risk of harm. They told us that they had attended training in safeguarding people at risk. They showed us what they had learnt as they were able to describe the types of harm that people might experience. Furthermore, the members of care staff were aware of whom to report to, should they suspect or witness such untoward incidents. In addition to this, members of care staff demonstrated their knowledge in recognising the signs and symptoms of people being harmed. One member of care staff said, "There could be a change in their character. Physical signs of bruising. Or not wanting to eat." Another member of care staff said, "They [person] could be trying to cover up [parts of their body]. Or being scared." We found that people had information held in their care files about how to raise a safeguarding concern.

One person in their survey told us that there were understandable reasons in the event that staff did not always arrive on time. The person wrote, "…you must bear in mind it is only when there is an emergency where someone has fallen or is unwell and extra care is needed for that person a carer may be late." Another person wrote that, although there was not always enough staff, "The care team here do a good job even if short staffed at times." The overall survey response rate showed that staff usually arrived on time and stayed the duration of the call visit. During our visit people told us that there was no delay of staff when they called for help. We saw there were two members of care staff providing people with the support and care that they needed. The staff took their time when helping people to and from the dining room. We also saw that members of care staff had the time to talk to people in a sociable way when collecting used crockery from their room.

Members of care staff said that there were enough staff on duty. They told us that, by 10:00 all of the people had their morning care as planned. One member of care staff said that they enjoyed their job. They said that this was because they had "plenty of time" to look after people without feeling rushed. They said, "I love it here. You've got time to give them [people] the care that they deserve." Both of the members of care staff said that measures were taken in the event that shifts were needed to be covered. One member of the care staff said, "The team leader or someone on call [will cover shifts]. We help each other out for annual leave or sickness." The head of care told us that the planning of staff rosters was based on people's needs and the needs of the staff. This was effective and met all parties' needs.

The provider told us that recruitment systems were in place to ensure that people were only looked after by suitable staff. In their PIR the provider wrote, "All employees have to undergo a comprehensive recruitment process, to ensure that all relevant checks are completed." One member of care staff described their recruitment experience. They said, "I had a DBS [disclosure and barring service criminal records check]. Two references, one from my previous employer. I came in for an interview and also I filled out an application

form on-line." They said that these checks had been carried out before they started their job."

To keep people safe, risks were assessed and measures were in place to manage the assessed risks. The records of these showed that risks included those associated with people's physical conditions and conditions of where they lived. Members of care staff were aware of such risks and how these were managed. One member of care staff told us that if any person was at risk of choking they were "to be sat up" when eating and drinking. They also added that the premises were kept secure by key codes to the main entrance of the building. In addition, people had their own keys to their doors. However, in the event that they were unable to use these, or in case of an emergency, staff had access to a securely held 'master' key. People's care records showed that people had signed to agree that staff could gain access to their rooms by means of the 'master' key, when this was needed. Records also showed that there was a tracking system in place so that names of staff were accounted for when they had access to the 'master' key. This was to maintain the security and safety of people's rooms and personal property, respectively.

Some of the people were independent with managing their medicines and had been assessed to be safe with this. This included ordering, storing, administration and disposal. One person said that they had asked a GP not to prescribe any more nutritional supplements as these were no longer needed. Some of the people said that they needed help with their prescribed medicines. One person told us that the community nurses gave them their prescribed injections. When they needed help from the care staff they said that they, "Check the records [medication administration records or MARs] before they give them [medicines] to me." MARs demonstrated that people had their medicines as prescribed.

When care staff were needed to help people with taking their medicines, this was carried out by trained staff. Members of care staff told us that they had attended such training. Furthermore, they had been assessed, during 'spot checks' to ensure they were competent with this practice. Staff training and 'spot check' records confirmed this was the case. One member of care staff said, "We are assessed frequently." The team leader told us that 'spot checks' were usually carried out every two months.

Audits had been carried out on people's completed MARs. When errors were identified, responsible individual members of care staff, attended re-fresher training in the management of people's medicines.

To keep people safe in the event of a fire, staff were trained and were aware of how to manage such events. One member of care staff said, "We have to check where the fire is and evacuate people into the car park. Or leave people in their room if the fire is compartmentalised [contained in one specific area]. As people will be safer in their room rather than be evacuated." People had information on the back of their doors about what they would need to do, in the event of a fire. This included evacuation procedures.

Good

Is the service effective?

Our findings

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

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. We found that people's rights were being protected from unlawful restriction and unlawful decision making processes. At the time of our inspection all of the people had the mental capacity to make decisions about their care. When people had re-gained their capacity to make decisions about end-of-life emergency treatment - that is resuscitation – this was being reviewed in conjunction with the person's registered GP.

Members of staff had attended training in the application of the MCA and DoLS. One member of care staff had knowledge about the role of the Court of Protection [CoP] in relation to DoLS applications. They said, "If a person does not have capacity to make decisions and they are unsafe [to leave the building or make financial decisions] we may have to go to the Court [of Protection.]" The head of care gave an example of how they involved the local authority, GP and a person's relatives in the mental capacity assessment process. This was in respect of a person who had short term memory loss which affected their safety when out in the community. The provider had clear policies in place to guide staff in relation to the MCA and DoLS legislation.

The provider told us in their PIR that staff received one-to-one supervision. This was to ensure that people were looked after by staff who were supported to do their job. Members of care staff told us that they had one-to-one supervision. This was the time during which they were enabled to discuss their work and any training needs they had identified. One member of care staff said that they had asked to be put on a nationally recognised training course; they told us they were now attending this career development opportunity. Other staff support systems included 'spot checks' when staff had received positive feedback about their work performance. In addition to these support systems, the staff supported each other. They said, "We are a small team and if we have any problems we share things with each other."

In their PIR the provider told us that people were looked after by trained staff. The PIR read, "Our staff receive training both internally and externally this enhances our staff skills…" Members of care staff said that they had attended a range of training. This included, for example, dementia care, health and safety, food hygiene and safe moving and handling techniques. People told us that they had confidence in the ability of staff. One person said, "I wouldn't be here if it wasn't for them." They described how members of staff applied their learning during the management of their life-threatening health condition.

People's nutritional health needs were met. People told us that they were able to make choices about what they wanted to eat, drink and where to eat their meals. They also said that they always had enough to eat

and drink. One person said that they had were independent in making their own meals and had salmon to cook for their evening meal. They said, however, that they had their lunch provided in the main dining area. Another person said that they were given the opportunity to have their lunch, with other people in the dining room. Nevertheless, they told us that they preferred the quietness of their own room to sit and eat all of their meals. One person said that they enjoyed their lunch of chicken and leek pie. They also told us that they were aware of healthy eating options and chose less calorific foods, such as yoghurts. This choice was as an alternative to, for example, steamed pudding and custard. The chef manager showed us that people had a choice of menu options and records of these choices were maintained.

We found that people's health needs were being met. People were empowered to manage their own health care appointments. One member of care staff said, "Some people have opticians coming in but people are independent with [arranging] this, or their relatives." One person said that they were able to make and attend appointments with a podiatrist, a GP and community nurses. They also told us that this support had enabled them to become more aware of how to manage their diabetes. Members of care staff had access to information in relation to the signs and symptoms of abnormal levels of blood sugars that might occur in people living with diabetes.

The nature of the care and premises maintained people's sense of well-being with the reduction of social isolation. We saw smiling people whilst taking part in a game of 'bingo' held in a large communal area of the building. During lunch time we saw people talking with each other in a sociable way. One member of care staff also added another aspect to this. They said, "We are probably the only people that they [people using the service] will see, if they don't have relatives."

Good

Is the service caring?

Our findings

All of the surveyed respondents, including the community professional, told us that the staff enabled people to remain as independent as possible. During our inspection we found that this was the case. One person said, "I can make my own drinks. I am not made to feel useless." One member of care staff said, "It's lovely that people have their own independence. Our job is to promote people's independence. To let them do the things they want to do." They expanded on this by telling us that the support and care enabled people to remain independent, but safer than when they were previously living in the community.

All of the returned surveys told us that people were treated with respect and dignity. People had positive comments about how well staff looked after them. One person said, "The staff are very good." One relative wrote a compliment to the staff. This read, "Very frankly speaking in my opinion this must rank as one of the very best places for frail elderly people to live…"

In their PIR the provider wrote, "Our aim is to employ the best possible staff, who are caring, compassionate and considerate, responsible and responsive to our clients' needs. We ensure that the service we provide is caring…" Members of care staff demonstrated the principles of good care. One member of care staff said, "We know these people so well. As we know them we can talk about their families, their past." The head of care was aware of people's individual life histories and accurately recounted one person's past and current social history. We saw members of care staff take their time when talking with people and explaining what they were intending to do. This included, for instance, when they were to help one person to go to the dining room for lunch. Another instance was when we saw a patient member of care staff explain to a person that they would ensure that a GP appointment would be made on their behalf. The person told us that they felt better with this reassurance.

People's right to privacy was respected. This included providing people with their own letter box to receive their mail in private. A communal post box was also provided for the posting of mail for collection. All flats were provided with lockable doors and door bells. One person said that after members of staff had knocked on their door or rung the door bell, they called out for staff to enter. They said that this was "safer" than having to get up and let the staff in.

People's right to making choices about how they wanted to live were respected. In all of their completed surveys people said that they agreed to the statement "I am involved in decision-making about my care and support needs." People told us that they had a choice of when they wanted help with personal care; what to eat and drink and if they wanted to be alone or with other people. Members of care staff were aware of offering people such choices. For example, the chef manager advised us that people's food preferences were accounted for and menu option alternatives were available for people to choose from.

There were no restrictions imposed on when people could receive their guests. One person told us that they had visits from their relatives "every day." Another person also told us that they had made friends with other people living in the same building. The head of care gave an example of this. They said that one person had received visits from one of their neighbours and enjoyed these occasions but was empowered to say when

and for how long the visit should be.

Good

Is the service responsive?

Our findings

In their completed surveys all of the people said that they were satisfied with how the care met their needs. People told us that they were satisfied with their planned care and how it met their needs. One person said, "They [care staff] do what they need to do."

The provider told us in their PIR how they aimed to be flexible in meeting people's needs. Their PIR read, "[We] Deliver person-centred care, which flexes and changes in response to changes in a service user's [people who use the agency] health and well-being. Our staff team understand that some days service users will feel more able to help themselves than other days and accommodate changes accordingly." One person told us that, following their discharge from hospital, they were unable to manage their own prescribed medicines. Therefore, the care staff had helped them with this. They said that, since their recovery, their care plan had been reviewed and now they were independent with the management of most of their prescribed medicines.

People were cared for in an individual way. People told us that they felt staff knew them as individuals with one person saying that staff "definitely" did. Staff were able to demonstrate their knowledge about people's individual needs. This was due to the nature of their work having the time to get to know people. One member of care staff said, "They [people] can talk to us. We know what jobs they used to do. As we get to know them we can talk about their families [relatives]. Their past." Information about people's life histories was recorded: comparing this information with what staff told us, showed that staff knew and looked after people as individuals.

Opportunities were created to meet people's social needs. Communal facilities and volunteering activities enabled people to take part in hobbies and interests. Other recreational activities included being taken out on trips. One person said how much they enjoyed their trips to a popular Norfolk sea-side resort and to a royal Norfolk country estate. The head of care also told us that the person was able to independently access the local shops.

People's right to be consulted about their care was valued. Assessments had been carried out by the commissioning authorities before the person started their tenancy and care. The assessments showed that, where possible, the person or their relatives were involved in their initial assessment process. People told us also that they had been involved in the reviews of their current care plans. We saw that these had been carried out and the person had signed to confirm that they had been actively involved. One person told us that there was one change that needed to be made. They said that this was in relation to their treatment in the event of a life-threatening event. The team leader advised us that arrangements were being made to up-date this information.

Members of care staff told us that people's care plans gave them the guidance that they needed to meet people's individual needs. One member of care staff said, "The care plans are easy. They just state what you need to know. They have to be updated if there are any changes, such as deterioration in their [people's] needs." People told us that staff "always" entered information in their daily records, which we found were

up-to-date. This was to ensure people's care was provided in a consistent way due to effective recorded communication.

Two thirds of the survey respondents told us they knew how to make a complaint. Furthermore the same amount of respondents said that they were satisfied with how their complaints were responded to. Because of this we explored this further during our visit. People told us that they knew who to speak with if they wanted to raise a complaint but had no cause to do so. The head of care and team leader advised us that no complaints had been received within the last 12 months. In their individual care files, people had access to information about the provider's complaints procedure. The information offered the provider's contact details and those for external agencies, such as the local ombudsman. This told us that people were enabled to raise a complaint but were very satisfied with how they were being looked after.

Good

Is the service well-led?

Our findings

In their surveys some, but not all, of the survey respondents said that they knew who to contact in the management office. Because of this we decided to explore this further during our inspection visit. During our visit people told us that they knew who to speak with and were able to name key managerial staff.

The registered manager was supported by a head of care, two team leaders and a team of care staff. We received positive comments by members of staff about the leadership style of the registered manager. We often heard staff describe them as "approachable" and always available to offer support and guidance. The community professional told us in their survey that they were satisfied with the management of the agency. This included satisfaction with sharing of information and improving care as part of the provider's complaints procedure.

Our review of the information we hold showed that the provider had submitted a notification when they were required to do so. This meant that the provider was aware of their legal responsibilities as a registered organisation and the requirement to be open and transparent as part of their 'Duty of Candour'.

The provider showed that they had a quality assurance process in place. This included carrying out unannounced 'spot checks' on staff. Members of care staff told us these were "frequent" during which they received feedback on the quality of their work. This included how they offered people choice about their care and respecting safe infection control procedures. Records of these 'spot checks showed that staff were carrying out safe care practices. However, the records omitted to detail the quality of how members of care staff engaged with people. The head of care and team leader recognised this was an area for the provider to improve upon.

In their surveys some, but not all, of the survey respondents said that the management of the service had asked for their views about the quality of their care. Because of this we decided to explore this further during our inspection visit. We found that reviews of people's care had been carried out in consultation with the relevant people. The head of care advised us that during 2016 the provider had also carried out surveys to obtain people's views. However, they said that this survey covered additional services run by the provider. The results of the surveys were said to be positive, although it was not possible to break this information down into individual services. This would have provided us with more meaningful information about people's views about the March located service.

Staff were enabled to influence in how the service operated. In their PIR the provider wrote, "Regular staff meetings take place to discuss quality of the service, any changes that need to be met, any improvements that need to be made and also looking at the things that we do well. Completing these meetings gives staff support as they are the key people in the care we provide." Members of care staff confirmed that they had attended such meetings and were able to contribute to the agenda items. One member of care staff said, "We discuss whatever is necessary to help or improve people's care." Minutes of these showed that staff were also reminded of their roles and responsibilities in making sure people received safe and appropriate care to meet their individual needs.

There was a whistle blowing policy in place. In their PIR the provider told us, "We have an open door and whistleblowing policy and ensure all staff adhere to it." Members of care staff were knowledgeable about this important procedure. One member of care staff said, "If I notice [name of staff] doing something I don't agree with, I would have to report it. It [whistle blowing procedure] protects me because it is confidential." This showed that there was an open culture operating within the management of the service.