Sunshine Homecare Limited

Sunshine Wisbech

Inspection report

Fenland House
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Wisbech
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Tel: 01945474700

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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

Sunshine Wisbech is registered to provide personal care to people who live in their own homes. At the time of this inspection care was provided to 77 people who lived in the town of Wisbech and surrounding Cambridgeshire and West Norfolk villages.

This comprehensive inspection took place on 12 April 2016 and was announced.

A registered manager was in post at the time of the inspection and had been registered since 2010 under the current legislation. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the agency. 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.

People were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were supported to take their medicines as prescribed.

People were supported to eat and drink sufficient amounts of food and drink. They were also supported to access health care services and their individual health needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. However, they were no arrangements in place to assess people's mental capacity; people's mental capacity was assessed by agencies who were responsible for funding their care. Some staff had an awareness of the application of the MCA.

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

People were treated by kind and respectful staff who they liked. They and their relatives were given opportunities to be involved in the review of people's individual care plans.

People were supported to reduce the risk of social isolation; they were helped to go shopping or take part in recreational activities that were important to them. Care was provided based on people's individual needs. There was a process in place so that people's concerns and complaints were listened to and these were acted upon.

The registered manager was supported by a team of management staff and care staff. Staff were supported and managed to look after people in a safe way. Staff, people and their relatives were able to make suggestions and actions were taken as a result. Quality monitoring procedures were in place and action was

taken where improvements were identified.

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.

People's needs were met by a sufficient number of suitably recruited staff.

Risks were managed to keep people as safe as possible.

People were supported to manage their prescribed medicines by trained and competent staff.

Is the service effective?

Good

The service was effective.

Staff were trained and supported to do their job.

The provider was acting in accordance with the principles of the MCA. However, there was a lack of staff training and inconsistent understanding in the application of the MCA. People's rights, however, were protected.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by staff who were kind and caring.

People's rights to privacy, dignity and independence were valued by staff.

People were enabled to make decisions about how they wanted to be looked after.

Is the service responsive?

Good

The service was responsive.

People were actively involved in reviewing their care needs and received care to meet their individual needs.

People were supported to visit the community and reduce the risk of social isolation.

There was a procedure in place which was used to respond to people's concerns and complaints.

Is the service well-led?

Good

The service was well-led.

There was an open culture operating in the management of the service.

Arrangements were in place for people and staff to make suggestions and comments.

There were quality assurance systems in place to ensure that people's care was well managed.

Sunshine Wisbech

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 announced inspection was undertaken by one inspector and took place on 12 April 2016.

The provider was given 24 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

Before the inspection we looked at all of the information that we had about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Also before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We received 37 out of 81 surveys sent to people who used the agency; four out of 81 surveys were received from relatives and nine out of 15 surveys were received from community professionals.

Prior to the inspection we made contact with a district nurse and a nutritionist. This was to help with the planning of the inspection and to gain their views about how people were being looked after.

During the inspection we visited the service's office and spoke with the registered manager, two care co-ordinators, a training and development officer, who was also the risk assessor, and three members of care staff. We spoke with four people and four relatives via the telephone.

We looked at four people's care records, medicines administration records and records in relation to the management of staff and management of the service.

Good

Is the service safe?

Our findings

People said that they felt safe from the risk of harm and all of the relatives said that they felt their family member was kept safe. One person said, "My mobility isn't good and the carers [staff] are always with me when I am walking about." One relative told us that they felt safe because of how the staff treated their family member and how they, too were looked after. They said, "[I feel safe] because of what the carers do. One day, I was still in bed, and the carers came up to see if I was alright. That's good as they didn't need to do this."

There were procedures in place to minimise the risks of harm to people. This included the training of staff in protecting people from such risks. Members of care staff told us what they would do if they suspected people were being placed at any risk of harm. They were able to describe the types of harm and the actions they would take, which included reporting the incident to the local authority. Staff were also aware of the signs of a person being harmed. They described the possible changes in people's behaviours and condition of their skin. One member of care staff said, "They [person] wouldn't be their normal self. They could be withdrawn. There could be bruises or marks that can't be explained." One care coordinator said, "The [person's] behaviour might change. You might see bruises or the person could become aggressive or withdrawn."

In the surveys some of the people and their relatives told us that care staff were not given enough time to travel between call visits. In a survey a relative wrote, on behalf of their family member, "Staff are expected to leave at clients at 1.30pm and to be here at 1.30pm. Totally impossible." One care coordinator explained the action that was taken in response to such concerns. They said, "We tend to re-organise travelling times and look at the geography of where people live." During our inspection people and relatives told us that staff arrived on time and staff told us that they had enough time to travel between care calls to people's homes. One member of care staff said, "Sometimes there may be minor delays but it is rare." One relative said, "Staff arrive usually in a few minutes [of the expected time of arrival]." People's daily records showed that staff arrived at the time they should and stayed the expected duration of the call visit.

The provider told us in their provider information return [PIR], "We are recruiting on a regular basis when current staff reduce their hours or our weekly workload increases." One care coordinator said, "There is enough staff to cover shifts. We are recruiting again." Staff told us that there was enough staff to look after people's needs and measures were taken to cover unplanned absences. One member of care staff said, "We have enough staff. The shifts are covered [if needed] by other staff." One care co-ordinator added, "There is not always enough staff when somebody suddenly goes off sick." The training and development officer and one care coordinator told us that they worked in the role of a member of care staff to cover these staff absences.

Risks were assessed and measures were taken to manage these risks. One relative told us that, before their family member started having care, they were involved in the risk assessment process. They told us that this included assessment of the home and, for example, the safety of the provision of electricity. The risk assessor told us that they carried out risk assessments, which included fire safety of people's homes. They

also told us that, when they had any concerns, they consulted the fire safety department for their advice in ensuring people were kept safe as far as possible. They said, "I called out the fire safety officer three times last week because of inadequate smoke alarms [in people's homes]." The action taken was for the provider to recommend to people that they should consider the replacement of their inadequate fire alarms.

People's care records showed that people's other risks were assessed and measures were carried out to manage these risks. This included risks associated with moving and handling. Measures were in place to provide two staff members and suitable equipment to safely support people with this mobility need. One person said that they felt safe when they were assisted with their moving and handling needs by means of a hoist. They told us that this was because there were "always" two staff available and were confident in the ability of staff to safely carry out this moving and handling practice. One relative told us that their family member needed assistance to transfer with the means of a hoist. They said, "There is always two staff and they know what they are doing." Staff told us and staff training records showed that staff were trained and assessed to be safe in carrying out moving and handling practices.

Members of care staff were aware of risks to the security of people's homes. One member of staff described the process of entering and leaving a person's home. They said, "If I need to get the key [from an outside key safe] I shield the key safe; punch in the code and get the key. I lock the box [key safe] up and 'scramble' the numbers so no one else can see the code. When putting the key back [in the key safe] I make sure I 'scramble' the numbers up before leaving." One relative confirmed that staff carried out this security measure to keep their home safe from unwanted visitors. They also said, "Staff always make sure the door is locked. And this makes me feel safe as well [as family member]."

The provider told us in their PIR that there was an out of hours on call system for people and staff to use if needed to keep people safe at all times. The PIR read, "A manager or senior care worker is on call out of office hours, so that there is always a trained carer to attend a service user should the need arise."

Recruitment of staff ensured that only suitable staff looked after people and staff recalled their experience of applying for their job. One member of care staff said, "I filled in an application form. Had an interview. Had a DBS [Disclosure and Barring Service] and written references from two people, one being my previous employer. I had to have these [checks] in place before I started." One care coordinator also described their similar experience of when they applied for their job. They, too, confirmed that all the required checks were obtained before they started their employment with Sunshine Wisbech.

A community pharmacist told us that people's medicines were safely managed. People were satisfied with how they were supported to take their prescribed medicines. One person told us that staff applied prescribed cream to their legs and this was carried out as directed by the prescribing GP. One relative also told us that they were satisfied with how staff applied prescribed creams to their family member. Members of staff described the process in supporting people with their prescribed medicines. One member of care staff said, "We don't give anything [medicines] if it isn't on the MAR [medicines administration record] charts. We check the medication against the MAR chart; the name; the dose. Then we 'pop' it [medicine] into a pot and pass the pot to the person. Once they have taken it [medicine] I sign the MAR chart." One relative said that the management of their family member's medicines was "always correct." MAR charts demonstrated that people had their medicines as prescribed.

A nutritionist told us that staff had attended training in giving people their medicines by their artificial feeding tube. The training and development officer told us that, as part of the staff induction, staff attended training in the management of people's medicines. Unannounced 'Spot' checks were carried out and records of these demonstrated that competency assessments were carried out when staff assisted people

with their medicines. The 'spot' check records showed that staff were assessed to be competent with this part of their role.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The provider wrote in their PIR, "All staff are aware of the Mental Capacity Act and are informed when a service user is known not to have capacity. They are trained to call the office for advice should there be any issues relating to this or they feel there is any deterioration in their capacity and how to recognise if a person deteriorates mentally, when we will speak to families and or other professionals for advice." The registered manager told us that they contacted the local authority and notified them when some people's capacity, to make decisions about their care and treatment, may not have been good as before. One person's record confirmed that this action was taken when their mental health needs had increased.

Staff told us that they had not attended training in the application of the MCA. The training and development officer said, "I've been trying to source MCA training for so long. I just can't get anyone to do it for domiciliary care services." Although staff had not attended training in MCA, some of the staff had an awareness of the application of the legislation. One member of care staff said, "[The MCA] is if someone is capable or has the ability to say what they want or do what they want." One care coordinator said, "If a person is assessed to say that they cannot make their own decisions, they need to have an advocate." The registered manager advised us that some of the people were legally represented by an appointee. Relatives, speaking on behalf of their family members, told us that they had no concerns about how their family member was supported in making day-to-day decisions about their care.

Care records showed that people's mental health needs were assessed although the assessment did not take into account people's capacity to make decisions. However, staff had access to an MCA policy which provided guidance in the application of the MCA and assessment of people's mental capacity. The registered manager and training and development officer gave us assurances that they would be seeking further guidance in the training of staff in the application of the MCA.

One relative said, "The staff are trained very well." Staff told us that they had the training, which included induction training, to do their job. One member of care staff described their induction training and said, "I had my moving and handling and medicines training and then I 'shadowed' [observed] two senior staff [looking after people] before I was allowed to work on my own." The training and development officer told us that the staff induction training enabled the provider to continually review and assess the competency and suitability of new employees. Records showed that staff also attended refresher training, which included moving and handling, food hygiene and dementia awareness. A nutritionist told us that staff had attended training in maintaining people's nutrition. This included assisting people with their nutrition via

artificial means. Information detailed in the PIR told us that there was an on-going development and training plan to increase the number of staff with a National Vocational Certificate and looking after people with end-of-life care needs.

Staff told us that they enjoyed their job because of the support they had to do their work. One member of care staff said, "I enjoy the team work here." Another member of care staff said, "I've worked for many years with other care companies, but this is one of the best I've worked for. If you need any help staff and managers are there." Staff also received support during supervision sessions. These enabled both staff and managers to review the wellbeing of staff and to discuss work related matters, such as people they looked after. One member of care staff said, "Any issues I have or with clients [people] or carers, we discuss [during my supervision]."

People told us that, if they needed support to maintain their nutrition, they were satisfied with how this was managed. One person said, "The carers always ask me what I want to eat. They will leave me a drink by my side and I always have got a drink." They also told us that the staff were aware of their individual dietary needs in relation to one of their medical conditions. Members of care staff were knowledgeable about assisting people to maintain their nutritional health. One member of care staff said, "People just tell us what they want [to eat] and we prepare it for them. We ask them if they want a hot or cold drink, or both and we make it at leave it by the side of them [to reach for]. One person we leave a flask of hot water so they can make a cup of coffee." Daily records showed that people's nutritional and hydration needs were monitored; advice was sought from community health care professionals, if needed, which included nutritionists/dieticians and district nurses. One care coordinator said, "We do speak with the dietician especially for those people who do not have family input."

People's health needs were met with support from staff, if needed. A district nurse told us that staff referred people "promptly" to them if they needed to and followed their health guidance when they looked after people. One person told us that they were dependent, but confident in how staff supported them in managing their health needs. They said, "My carers are very observant because of my health conditions." They told us that this level of understanding had helped them to keep healthy and safe.

Incident records showed the appropriate action staff had taken in response to people requiring emergency health care assistance. One member of staff also described the appropriate action they had taken when a person had become unwell as a result of an underlying medical condition. This included making sure the person was kept safe and comfortable before calling for emergency health care assistance.

Good

Is the service caring?

Our findings

We received positive comments from people about how well they were looked after. One person said that they were very satisfied with how staff treated them. Another person said, "The staff are so patient with me. It helps me a lot." One relative said, "The staff are very good. They always ask what my [family member] wants." Another relative said, "The staff are excellent. The best care we have ever had. They treat [family member] with dignity." During 2016 the provider had sent out questionnaires to people to ask them for their views about the service: 47 of these were returned and results showed that people considered that staff respected their dignity. A district nurse told us that people were treated with respect and dignity.

Staff were aware of the reasons for providing people with care. One member of care staff said, "Everybody is different and has different needs. My job is to keep them as well as possible. To be a good listener; caring and compassionate." Another member of care staff said, "It is to enable people to stay at home." Some of the relatives we spoke with were the main carer for the person who was using the service. One relative said, "The care really helps me. The caring [for family member] was too much for me. It was exhausting." They told us that the provision of their family member's care had enabled them to stay at home together.

The training and development officer told us about the aims of the care provided by Sunshine Wisbech. They said, "Promoting people's independence. That is what domiciliary care is about. Give people choices all of the time. We don't want to take everything away from them." A community professional told us that staff enabled people to regain their level of independence, following their discharge from hospital. People's independence was maintained and promoted which included self-management of their medicines and personal care.

People, and relatives on their behalf, told us that staff offered choices about how they preferred to be looked after. One person said that during their preliminary assessment, the registered manager had asked them if they had any gender preferences of staff. They said that they had asked for female staff and that this request was respected. One relative said, "[Family member] would not like to have male carers. It was one of the questions we were asked when we setting up the care package." Another relative told us that their family member liked to be dressed in 'casual' clothes and their preference was respected.

To forge good relationships between staff and people they looked after, staff looked after the same people most of the time. One person said, "My carers are the same. I like that." One relative said, "It's a routine that's now been created [family member] recognises the staff and knows who's coming in." They told us that this was important to their family member and that a level of trust had been built up. This had, in turn, enabled their family member to allow care staff to improve the standard of their personal care. Another relative said, "Regular staff are now being established. It's nice having regular staff and we are getting on very well with them." One care coordinator said, "A lot of the calls go to regular staff; we don't like putting different staff in all of the time."

People, and people's relatives, were involved in developing care plans. This was during the planning stage of setting up the care package. One person said, "I am involved in my care plan." One relative said, "[Name of

training and development officer] came and filled in a lot of forms. I was involved in everything."

Good

Is the service responsive?

Our findings

A community health care professional praised how staff responded to people's needs when they were discharged from hospital. People said that they were satisfied with how their individual needs were met. One relative told us how their family member's continence needs were managed and said that this had met their family member's individual needs. Another relative told us that staff understood their family member's mental health needs and responded to them in the way that they should. This included engaging with their family member's sense of reality. Staff had received a number of compliment and 'thank you' cards which showed that people and their relatives were satisfied with how people's needs were met.

Care records showed that people's moving and handling needs were assessed and equipment was obtained and provided to maintain people's safety and independence. The training and development officer told us that the equipment included raised toilet sets and moving and handling equipment, such as commodes and hoists which could easily be moved.

People's care needs were assessed and based on people's individual care needs. One relative said, "Before [family member] had the care [family member] wasn't taking their medicines and weren't showering or washing. Now I've seen a difference [as a result of the care provided]." One person told us that the care helped them go out in the community and reduce the risk of social isolation. They said, "A carer [staff] takes me out every Thursday to do a bit of shopping; have a drink or something to eat out." Members of care staff told us how they supported people to access the community. One member of staff told us that this included taking people to go shopping and eating out.

Care plans and risk assessments were reviewed and kept up-to-date to help ensure that staff had access to information that protected people from unsafe or inappropriate care. One person said, "My medication was changed and this was changed in my care plan." One relative told us that their family member's needs had changed. An increase in the times of call visits was made and this change was reflected in the person's care records. Another relative told us that their family member's care plans were kept up-to-date; they said, "The carers [staff] are always updating the care plans and risk assessments."

Information about people's individual needs and their life histories was made available for staff before they looked after people who were new to them. One member of care staff said, "Today I visited two new clients [people]. I had all the information about the person [before I looked after them]." People and relatives told us that due to the consistency of regular staff, this had enabled staff to get to know people and people had got to know the staff.

People and relatives told us who they would speak with if they wanted to raise a concern or complaint. One relative said, "I would speak to [name of registered manager]. She is the top one isn't she." Another relative said, "I rang [name of registered manager] and she sorted my concerns out." Members of staff were aware of supporting people to make a complaint and told us that this would be by following the provider's complaint procedure.

The provider told us in their PIR that they had received three complaints within the last 12 months. All of these had been responded to in line with their complaints policy. Although a low number, the provider had taken remedial action in response to people's complaints. The PIR read, "The recurring theme is that of clients not being notified of time changes. We have now employed an extra Care Co-ordinator to help, not only with compiling rota's but also noting down any changes and calling the service user involved." People and their relatives told us that the standard of communication from office staff was 'good'." One of the provider's questionnaires, completed by a relative for 2016, read, "I think any communication problems have been resolved." One relative said, "I have nothing to complain about; they are all wonderful."

Good

Is the service well-led?

Our findings

We received positive comments about the leadership style of the registered manager. People told us that they knew her name and found her to be accessible and approachable. One relative said, "I rang [name of registered manager]. I always get an answer." Another relative said, "[The registered manager is very lovely; caring; very listening and understanding of what I was saying. [Sunshine Wisbech] is a very good company under her direction."

Staff were enabled to make suggestions in improving the standard of people's care. One member of care staff gave an example of this; they told us that during their supervision they requested a change in their work schedule. This was so that there was no delay in arriving at people's homes, due to a reduction in travelling time. Staff members also told us that the registered manager was available and this helped them have discussions about their work with her. The registered manager was supported by a team of staff, which included the risk assessor. One member of care staff said, "If I noticed a person tripping over a mat, I would ask [name of risk assessor] to carry out a risk assessment." They told us that action was taken to remove a mat, with the person's permission, as this had posed a risk of a trip hazard.

People and their relatives were invited to share their views about the standard and quality of the care by completing the provider's questionnaires. The results of the questionnaire survey for 2016 had yet to be complied although there were favourable comments added to these returned questionnaires. This included people's satisfaction in the way that staff treated them and met their care needs.

'Spot checks', which were carried out to assess the standard and quality of staff members' work, also enabled people and relatives to share their views about the quality of their care. One care coordinator said, "We would speak with people during 'spot checks' and ask them if they were happy about any particular part of the service. For example, a carer [staff]. I would also ask them if there was anything that they didn't like." One relative said, "I have had a senior carer come and oversee what the carer was doing. I was also asked if there was anything to be changed [in their family member's care]." One relative told us that they were satisfied with changes made in staffing arrangements as a result of their comments made during a 'spot check'.

Members of staff told us that spot checks were unannounced and described the process. One member of care staff said, "[A senior member of staff] observes. Just making sure we are caring for people in the correct way. And following the care plan." Another member of staff also told us that they were observed supporting a person with their prescribed medicines. They told us that they received feedback to improve their technique in measuring out prescribed liquids. One care coordinator said, "The unannounced spot checks are to observe their [staff] work; the communication with people; the delivery of their care; handling medication; we looked at how they are recording." Records of 'spot checks' on staff showed that staff provided people with safe and dignified care and that records, which included MAR charts, were complete and accurate.

Staff were aware of the whistle blowing policy and when to use it. One care coordinator said, "Whistle

blowing is if someone comes to me about a member of staff. The way that the staff member is treated is confidential and taken seriously." One member of care staff said, "Whistle blowing is when I can speak to somebody [about a colleague] and their names, or mine, will be kept confidential."

The provider's PIR showed that there was a system in place to continually review the quality and safety of people's care. This, for example, was identification of staff training and development needs; recruitment of new staff and improved monitoring of staff when they completed individual call visits.