Intrigue Homecare Ltd

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Inspection report

Suite B5, Pembroke House
Northlands Pavement, Pitsea Centre, Pitsea
Basildon
Essex
SS13 3DU

Tel: 01268553578

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place 20 and 23 July 2018 and was announced. This was because the service was a small organisation and we needed to be sure someone was in to help us carry out our inspection. This was the first comprehensive inspection of the service since the service was registered in February 2017.

Intrigue Homecare Limited provides a supported living service to people in their own homes, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service was delivered from a large detached property which was located close to the seafront and all local amenities. The house could accommodate up to five people. At the time of our inspection there were two people using the service.

The care service has been developed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. 'Registering the Right Support' CQC policy.

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

People were safe living at the service. Risks to people had been assessed and management plans were in place to minimise the risk of harm. Staff knew what to do to keep people safe without imposing unnecessary restrictions on people's freedom.

Staff had been trained in how to protect people from the risk of abuse. There was a whistle-blowing policy in place which provided guidance to staff on how to report any concerns in the workplace.

Medicines were managed safely and staff had been trained and assessed as competent to administer people's medicines. There were sufficient staff deployed who had been safely recruited to meet people needs.

Training and supervision was provided to support staff to be competent in their role and ensure they had the skills and knowledge to provide effective support.

Consideration had been given to people's mental capacity and where required support was provided to help people make their own decisions and choices.

People were supported to have enough to eat and drink and have access to health care services to maintain their health and wellbeing.

Staff were kind and caring and listened to people and included them in how their care and support was delivered. Staff treated people with dignity and respect and helped people to be as independent as they could be.

People's needs were holistically assessed so that staff could provide individualised care that met each person's needs and preferences.

The service supported people to have access to activities of their own choosing and opportunities for socialisation in the local community.

There were systems and processes in place to manage complaints. People's wishes for their end of life care were known and respected.

The service was well managed by a registered manager who was hands on at the service providing support and oversight of the staff team.

People and staff were included in the running of the service. Feedback was actively sought and used to improve the service.

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.

Risks were identified and managed by staff who knew how to keep people safe from harm.

There were sufficient staff to meet people's needs who had been safely recruited.

Medicines were well managed and lessons had been learned to improve safety.

Is the service effective?

Good

The service was effective.

People's needs were holistically assessed to ensure the service could provide effective care and support.

Staff received supervision and training to ensure they were competent in their job role.

People were supported to make their own decisions and choices.

Support was provided to ensure people had enough to eat and drink which met their needs and preferences.

The service helped people stay healthy by arranging and supporting people to attend healthcare appointments.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and knew people well.

People felt listened to and were included in decisions around their care and support.

Independence was promoted.

Is the service responsive?

Good

The service was responsive.

People received care and support that met their needs and preferences and was delivered in a person-centred way.

The service supported people to engage in activities of their choosing in the service and the local community.

People knew how to make a complaint. There were systems and processes in place to manage complaints appropriately.

End of life care had been considered and people's wishes and preferences were known and upheld.

Is the service well-led?

Good

The service was well led.

The registered manager was 'hands-on' and had a good level of oversight of the service on a day to day basis.

The staff team understood and shared the service's values of supporting people to be included and have choices and independence.

People and staff were included in the day to day running of the service and feedback was sought to drive improvements.

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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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was announced and was completed by one inspector. We gave the service 48 hours notice of the inspection visit because we needed to be sure someone would be in.

Prior to this inspection we reviewed all the information we held about the service including statutory notifications sent to us by the provider. Statutory notifications provide us with information about important events which the provider is required to send us by law.

Inspection site visit activity started on 20 July 2018 and ended on 23 July 2018. During this time, we spoke with the registered manager, two staff members and one person who used the service. We looked at two peoples care records and three staff files and looked at information relating to the management of the service such as training records, supervision notes and quality monitoring audits.

Good

Is the service safe?

Our findings

There were systems in place to ensure people's personal possessions were stored securely and kept safe. People told us they felt safe using the service. One person said, "I do feel safe here, it's taken thirty-five years but finally, living here I have found peace."
Staff had received training in safeguarding and understood how to protect people from the risk of abuse. There was a safeguarding policy in place and the provider was aware of their responsibilities to report any concerns to the local authority and the Care Quality Commission (CQC). We saw that systems and processes were in place to raise safeguarding concerns if necessary in accordance with their safeguarding policy.

Information on safeguarding was included in peoples care plans to educate them about abuse and how to report any concerns. This information was provided in an easy read format to support people's understanding.

Risks to people had been identified and were recorded in people's care plans. There was guidance in place for staff on how to manage any risks to keep people safe. The registered manager and staff including permanent and agency staff demonstrated a very good awareness of risks to the people they supported and knew what to do to minimise the risk of harm. For example, one staff member told us, "[named person] has had previous issues with substance abuse and can relapse; we look for signs to check if they are becoming quiet or withdrawn." Risk was managed positively so that people's rights and freedom was upheld. One person told us, "It's the best place I have ever lived; I have freedom; I can come and go as I please."

Staffing levels were determined according to the needs and requirements of the people living at the service. One person received one to one support twenty-four hours a day and we observed this was in place to ensure their needs were safely met. Where it was necessary to cover absences due to sickness or leave, the registered manager covered shifts. This provided consistency in support for the people using the service. Recruitment was ongoing and in the interim two agency staff were used to maintain safe staffing levels. These were regular agency workers who had been employed since people began using the service, again providing continuity of care for people. An on-call system was in place to support staff out of hours and staff were familiar with the system and aware of who they could call for advice when required. Staff confirmed they were always able to contact the registered manager for advice and guidance whenever necessary. They told us that the registered manager visited the property every other day or more to provide support and oversight.

Robust recruitment processes were in place for the safe recruitment of staff. This included obtaining satisfactory references; completing identity checks and recording staff members full employment history including exploring any gaps in employment. Checks by the Disclosure and Barring Service (DBS) were also completed. The DBS provides information about people's background, including convictions to help employers make safer recruitment decisions.

There had been no accidents or incidents to report but systems and processes were in place should the need arise. Reporting forms were included in people's care records along with a body map form for staff to

record where any injuries had occurred.

Appropriate systems and processes were in place for the safe management of medicines in accordance with the provider's medicine management policy. Medicines were kept securely in locked cabinets in each person's room. Staff had received training in how to administer people's medicines and had their competency assessed by the registered manager. However, we found that the current competency assessment lacked detail which meant we could not be sure that all aspects of medicine management had been thoroughly assessed.

We discussed our findings with the registered manager and made a recommendation that they review their current method of assessing staff competence to administer medicines to include a more detailed assessment of staff practice.

Medicine administration records (MAR) were used to record when people were given their medicines. We looked at people's MAR charts and saw there were no gaps in recording which demonstrated that people had received their medicines as prescribed.

Lessons had been learned to improve the safety and quality of medicine management. The service originally used their own MAR charts but had now switched to using charts provided by the pharmacy. The new forms were easier for staff to understand and complete and made it easier for the registered manager to check the stock counts. This helped the manager to complete their medicine audits to check that people had consistently received their medicines.

The provider had a policy in place for infection control and staff had received training in infection control and food hygiene. Protective clothing such as gloves and aprons were available for staff to help control the spread of infection.

Good

Is the service effective?

Our findings

People told us they received a good service which met their needs. One person said, "I have only been here for five weeks but they have done more for me now in five weeks than I have had help with in the past thirty years; I would recommend this service to anyone."

When people joined the service an assessment was completed to check that the service could meet their needs. The assessment recorded people's needs and choices and consideration was given not only to people's physical needs but also their social, psychological and emotional needs. Where people had behaviours that could be perceived as challenging, support plans were in place to provide guidance to staff on how to manage them. Staff were knowledgeable about triggers for people's behaviours and how to interpret and diffuse situations. For example, one staff member told us, "I know if [named person] is agitated, they will make a certain noise, or take off clothes; when this happens we give them their own space."

When staff joined the service they received an induction which was based on the care certificate standards which represent best practice for inducting staff into the care sector. The induction included completing a mandatory programme of training which met the individual needs of people who used the service, for example, training in mental health awareness and learning disabilities. Training was provided via E-learning and also face to face for the more practical elements such as manual handling and first aid.

The induction process also involved new staff shadowing existing staff and the registered manager to learn about the role and how to meet people's needs in the way they wanted. The shadowing lasted for a week and this time was also used for the registered manager to monitor the skills and performance of each new worker to ensure they could effectively meet people's needs.

There were systems and processes in place to be able to provide regular supervisions and annual appraisals to staff which are used to assess staff competence and identify learning needs. However, at the time of inspection no staff had received an annual appraisal of their practice as they had not been employed at the service long enough.

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. At the time of inspection there was one person using the service who lacked capacity to make certain decisions. We saw that in this instance, appropriate assessments had been undertaken to ensure the person's rights were protected and that any decisions made on their behalf were in their best interests.

Staff had received training with regard to understanding their roles and responsibilities in relation to the MCA and understood how to support people to make their own decisions and choices. We spoke with a person who used the service who told us that staff always asked for their consent before providing any care

and support.

Where required staff supported people to have enough to eat and drink that met their health needs and preferences. Staff supported people with shopping for food and assisted with meal planning and preparation if necessary. People's likes and dislikes regarding food and drink were known and respected by staff. One person told us how staff had helped them learn how to make a roast dinner. They told us this had been an enjoyable experience which had brought back happy memories of time spent with their aunt.

Staff, including the registered manager were very knowledgeable about the type and level of support each person required with eating and drinking. The registered manager told us about one person's needs; they said, "[named person] can eat finger food independently, they eat fast so we cut it up small so that they don't choke; we guide their hands to their drink and make sure they are cooled off." We looked at the person's care records and saw the information recorded matched what we had been told. This demonstrated that people's care records held up to date and accurate guidance to help staff meet people's needs safely and effectively.

People were supported to have their healthcare needs met in a timely fashion and referrals were made to health professionals such as occupational therapy and mental health services where required. The service took a person-centred approach with regard to how they supported people to access healthcare services. For example, where a person had a fear of transport, health appointments were organised which took place in the person's home to minimise their distress. We saw this person had been visited at home by the GP and the mobile dentist service. Advice provided by healthcare professionals was listened to and people's care records were updated to reflect any changes. For example, after a person's dental appointment we saw their personal care plan had been updated to reflect the dentists advice.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. One person said, "The staff are kind, I can talk to them about anything." We observed care staff interacting with people and saw that staff were warm and friendly and people seemed relaxed in their company. We saw staff interacting with people in a positive way and listening to people. One person told us, "I can talk to these girls [care staff] about anything."

People were supported by a consistent and stable staff team. This meant that people and staff had got to know each other well and had built a good rapport. Staff we spoke with showed they had a good understanding and an appreciation of people's individual needs. For example, one staff member told us, "[named person] likes to be told they look smart." and, "When [named person] has a shower they like you to sing; if you don't they will refuse to shower." People confirmed that staff knew them well. One person told us, "I think they [staff] know me really well here."

Staff understood the importance of treating people with respect and maintaining their dignity and privacy. We observed that staff were polite to people and treated them respectfully and this was confirmed by feedback we received. A person told us, "The staff have been very respectful from the word go."

From April 2016 all organisations that provide NHS or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. The provider was meeting the Accessible Information Standard and had developed accessible ways of communicating with people, such as easy read documents, to support people to tell staff about their needs and wishes, be involved in planning their care and make a complaint.

People had care plans which provided guidance to staff on how to communicate with them ensure they were included in how their care and support was provided. One person had limited verbal communication skills. Staff we spoke with demonstrated a good awareness of how to communicate with this person using both verbal and non-verbal means and how to interpret the person's behaviour. For example, one staff member told us, "[named person] will say 'nunnight'; to tell us they want to go bed." We saw the service was supporting this person by making a referral to speech and language therapy to try to help them improve their communication skills.

We looked at how the service recognised equality and diversity and protected people's human rights. Care records captured key information about people including any personal, cultural and religious beliefs. We saw that people who used the service could request a preference of gender of care worker and this was respected to help people feel comfortable and at ease with receiving care and support. One person told us, "I prefer females so I get supported by women here."

The service provided equality and diversity training to all staff to promote awareness of the importance of respecting people's individual beliefs. We saw that one person had particular religious requirements and the service had been pro-active in finding out how to support the person and putting the appropriate support in

place to reflect their wishes. This demonstrated that the service was committed to promoting a positive and inclusive environment.

Where appropriate, people were supported to access advocacy services. This ensured people's interests would be represented and they could access appropriate services outside of the service to act on their behalf if needed. We saw that one person who used the service had their own advocate to provide them with support to make choices and ensure their needs and preferences were met.

The service supported people to maintain their independence. People were provided with encouragement and prompting to do things for themselves. On the day we inspected we observed a person cooking themselves lunch independently. This person told us they were quite capable of completing most tasks on their own but that staff would step in and provide help and support if needed.

The provider and staff team understood the need to keep people's information confidential. We saw that personal information held about people was kept secure which meant that confidentiality was respected and maintained.

Good

Is the service responsive?

Our findings

When people joined the service, they had an assessment of their needs and their strengths and abilities were recorded. A care plan for each person was designed to reflect the person's needs and wishes. The care plan included information about the persons likes, dislikes and preferred routines which supported staff to provide person-centred care. Person-centred care is care tailored to meet each individual's needs in a personalised way.

People had only been receiving a service for a short while so had not yet had a review of their care plan. The registered manager told us that people's care records were 'live documents' which would be added to as they got to know the people they supported and updated as and when things changed.

People were encouraged and supported to participate in activities of their choosing and access the wider community. One person told us about their experience of being supported to access leisure opportunities. They told us, "I get to do art and poetry and gardening and I'm going to college now; I have not had to wait for anything, they are helping me so much."

There were systems and processes in place to manage complaints. At the time of inspection there had been no complaints made about the service. Information on how to make a complaint was provided to people in an accessible format. People told us they knew how to complain but had not had to. One person told us, "I have nothing to complain about since moving here."

The service supported people to have their wishes met for their end of life care. The registered manager told us how they had worked in partnership with a particular religious affiliation to ensure that a person's specific wishes for their burial would be organised appropriately. Specific materials had been purchased and the persons funeral needs were documented in their care plan so that all staff had the necessary knowledge to support the person in the way that they and their relatives had instructed.

Good

Is the service well-led?

Our findings

There was a registered manager in post who understood their registration requirements, including notifying us of events that affected the service. Our discussions with the registered manager and staff team demonstrated that the positive values of choice, inclusion and promotion of independence underpinned how care and support was delivered.

The registered manager was 'hands-on,' overseeing staff, talking to people and providing care and support when required. Staff told us the manager was accessible and approachable and they felt well supported. One staff member told us, "I feel very well supported; I can ring them [manager] anytime; they ring me all the time to check in with me and are here most days to check in with staff."

Staff were clear about their roles and responsibilities. Duties were identified each day when staff changed over at each shift to ensure accountability and consistency of care. Communication, appointment and request books were used to share information to ensure staff were aware of any changes to people's support needs or wishes.

Systems and processes were in place to monitor the safety and quality of the service. We saw that the first medicine audit had been completed which was very detailed and had picked up on areas requiring improvement. The manager also completed regular spot checks of staff performance when they visited the property and read people's daily notes to check that people were receiving the care and support that had been agreed.

People were included in the running of the service. The registered manager kept a feedback folder which was used to gather information on people's views. We saw that the manager contacted each person, or their representative if appropriate, on a weekly basis to check if they were happy with the service they were receiving. Feedback was used to make any necessary improvements. For example, one person's relative had requested that a radio be purchased for their family member who enjoyed music. We saw that the service had promptly acted on this request.

Staff were also included in the running of the service as the registered manager visited staff most days to ask for their input. There were plans to introduce monthly staff meetings so that staff involvement could be formally recorded.

The registered manager worked in partnership with external organisations for the benefit of people who used the service. They had formed links with a voluntary organisation that supported people with volunteer, employment and leisure opportunities. To keep up with best practice and access relevant training opportunities the manager had registered with various professional organisations relating to learning disabilities and mental health. The manager had also been proactive in ensuring their continuous learning and development and had completed various training courses, for example, mental health, leadership and promoting physical and mental health.