Manorcourt Care (Norfolk) Limited

Manorcourt Homecare

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This was an announced inspection that took place on 25 February 2016 and 03 March 2016. On 25 February 2016 we visited the central office of the service and on 03 March 2016 we made phone calls to people who used the service to obtain their feedback on the care that was being provided.

Manorcourt Homecare is a service that provides personal care to people in their own homes. At the time of the inspection, 150 people were receiving care from the service.

There was a registered manager working at the service. 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 and associated Regulations about how the service is run.

People received care from staff who were kind and caring and who treated people with dignity and respect. The staff were well trained and the provider had systems in place to protect people from the risk of abuse. There were enough staff to meet people's needs.

People received their medicines when they needed them and staff asked them for their consent before providing them with care. The staff acted within the requirements of the Mental Capacity Act 2005 when providing care to people who were unable to consent to it themselves.

People's care needs had been assessed and were being met. However, staff sometimes did not provide care at people's preferred times. Information was not always in place to guide staff on what care they needed to provide to meet some people's specific needs.

The systems in place to monitor the quality of service being provided were effective. Audits had been conducted that had identified improvements that were required to the service and these were being worked on.

The staff were happy working for the provider and felt supported in their role. The provider had promoted an open culture where both staff and people using the service could raise concerns without any hesitation. People knew how to complain and any complaints were investigated and responded to.

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 knew how to protect people from the risk of abuse and took action to reduce risks to people's safety.

There were enough staff to meet people's needs.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had received training to enable them to provide people with effective care.

Staff understood their legal obligations on how to support people who could not consent to their care.

Where the service was responsible for providing people with food and drink, this was being received and met people's needs.

Staff would assist people to contact other healthcare professionals if needed to support them to maintain good health.

Is the service caring?

Good

The service was caring.

The staff were caring and kind and treated people with dignity and respect.

People were not always visited by the same staff which meant it was sometimes difficult for staff to develop positive and caring relationships with people. However, improvements were being made in this area.

People's independence was encouraged and they felt involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People received care that met their needs but some of their preferences had not been assessed and/or were not always being met.

People's care needs had been assessed. Guidance for staff on how to meet these needs required improvement.

People knew how to make a complaint and any complaints made had been investigated and responded to.

Is the service well-led?

Good

The service was well-led.

The staff felt supported and listened to and were able to raise concerns without fear of recrimination.

There were effective systems in place to monitor the quality of the service that was provided.

People were asked for their opinion on how to improve the service and these were acted upon.

Manorcourt Homecare

Detailed findings

Background to this inspection

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

This inspection took place on 25 February 2016 and 03 March 2016 and was announced. The provider was given 48 hours' notice before we visited the office because the service provides care to people within their own homes. The provider and staff operated from a central office and we needed to be sure that they would be on the premises so we could speak with them during the inspection. On 25 February 2016, one inspector visited the central office of the service and on 03 March 2016 another inspector made phone calls to people who used the service or their relatives to obtain feedback on the care that was received.

Before the inspection, we requested that the provider complete 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. This was received from the provider. We also reviewed other information that we held about the service. We had requested feedback before the inspection from the local authority safeguarding and quality assurance teams.

During this inspection, we spoke with 13 people who used the service and two relatives of people who received care from Manorcourt Homecare. We also spoke with five staff, the registered manager and the provider's regional compliance & quality officer.

The records we looked at included seven people's care records and other information relating to their care and five staff recruitment and training records. We also looked at records relating to how the provider monitored the quality of the service.

Good

Is the service safe?

Our findings

All of the people we spoke with told us they felt safe when the staff provided them with care. One person told us, "I don't have any worries." Another person when asked if they felt safe said, "Yes I do." A relative said, "[Family member] would tell me if there was a problem. I have no concerns about their welfare."

All of the staff we spoke with knew how to protect people from the risk of abuse and told us they received regular training on the subject. They understood the different types of abuse that could occur and how to report any concerns. Any issues identified by staff had been reported and investigated appropriately. We were therefore satisfied that the provider had taken steps to protect people against the risk of abuse.

The people and relatives we spoke with told us they had discussed risks to their or their family member's safety when they started using the service. They added the staff did remind them about safety when they visited them. One person told us, "I think they talked to me about that when I first spoke to them." Another person said, "They do talk to me about that sort of thing." A relative told us, "I've discussed it with them [the staff] to be sure my relative is safe."

We saw that risks to people's safety had been assessed. These included risks in relation to supporting people to move, taking medicines, equipment they used and the environment. Where necessary, other risks such as falls had been looked into. There was clear information within these assessments to guide staff on how to reduce these risks. The staff we spoke with were knowledgeable about risks to people's safety and were able to explain to us how they managed these. For example, making sure that people used appropriate equipment when walking.

The staff were able to demonstrate to us they understood what action to take in the event of an emergency, such as if they found someone unconscious when they visited their home. We saw an example of this where it had been recorded in one person's care record. The staff had found the person unwell and so had requested the emergency services to assist the person.

Records showed that when incidents or accidents had occurred whilst staff had been providing people with care that these had been investigated by the manager. Action was taken to reduce the risk of the incident from occurring again to help keep people safe. We were therefore satisfied that risks to people's safety had been assessed and that actions were being taken to mitigate these risks.

The people and relatives we spoke with told us there were enough staff to meet their needs. They added that the carers always arrived to provide them with care and that they had not experienced any missed calls. All of the staff we spoke with told us that there were enough of them to meet people's needs.

The number of staff required to meet people's needs was based on the number of hours of care the provider had to give. The registered manager told us they currently had enough staff in place to meet people's needs. The provider used bank staff and existing staff to cover any absences such as sickness or annual leave. We were therefore satisfied that there were enough staff to meet people's needs.

From looking at staff employment records, we saw that the provider had carried out all the required checks to make sure that staff were of good character and safe to work with people before they employed them.

People told us they received their medicines when they needed them. One person told us, "They [the staff] call to make sure I have my eye drops and help me with them." Another person said, "Yes they usually call at the same time so I have my tablets then."

The staff we spoke with told us they could be involved in either giving people their medicines, prompting the person to take them and/or collecting the person's prescription from the pharmacy. They confirmed to us that they had received training on how to give people their medicines safely.

We checked three people's medicine records. These indicated that two people had not received their medicines as prescribed. We spoke to the registered manager about this. They advised that these issues had been identified during recent audits. They added that the gaps in records were due to staff not recording that they had given the person the medicine, rather than the person not receiving the medicine. We saw audit records to confirm that this was the case. Staff had recently been reminded about the importance of completing medicine records accurately during a staff meeting. Records confirmed that staff's competency to provide people with their medicines safely had been regularly assessed.

Good

Is the service effective?

Our findings

The people and relatives we spoke with told us they felt the staff were well trained and had the necessary skills to meet their needs. One person told us, "They [the staff] have the training they should have." Another person said, "I don't think there is a problem with that sort of thing."

All of the staff we spoke with told us they had received enough training to give them the skills and knowledge to provide people with effective care. Staff had received training in a number of subjects including how to support people to move safely, food and nutrition, infection control, safeguarding adults and dementia. One member of staff was currently completing a qualification through the Dementia Alliance to enable them to become a dementia coach. The aim of this was for them to provide coaching to other staff to help them improve their skills and knowledge regarding dementia.

A training manager was employed to provide the training to the staff. There was a comprehensive programme in place each month for staff to attend. This covered many different subjects that enabled staff to improve their knowledge and skills within specific areas. Some of these areas included pressure care, mental health, percutaneous endoscopic gastrostomy (PEG) feeding, stoma care and catheter care. The training consisted of a mixture of classroom based practical training and e-learning.

New staff received a comprehensive induction to their role as a carer. Part of their induction involved them shadowing a more experienced member of staff until they were confident they could work independently. During their induction period, their competency to perform their role was regularly assessed and feedback given to them as necessary. We spoke with a new member of staff who told us the induction training was very good and that they were given time to learn the skills they required. They added they were being give lots of support to increase their confidence and that they were not being unduly pressurised to work independently before they felt ready.

The staff we spoke with told us they had regular supervision with the senior staff. This involved face to face meetings and appraisals. All of the staff we spoke with were happy with the amount of supervision they received.

People told us that the staff asked for their consent before they provided them with care. One person said, "I have been asked for my permission". Another person told us, "That's never been an issue, I tell them what I would like and they do it." Most of the care records we looked at had been signed by the person who was receiving care from the service to show they had consented to it.

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 provider was working within the principles of the MCA.

All of the staff we spoke with could tell us how they supported people who lacked capacity to make decisions for themselves. For example, by showing people a choice of clothes to wear or food to eat. They were aware that if the person was unable to make a decision for themselves, that any decision made on their behalf needed to be in the person's best interests.

People told us that where it was part of their care package, that staff prepared their food and drinks to their liking. They added that staff monitored how much they ate and drank and reminded them of the importance of this. One person told us, "They [the staff] remind me to have something to eat and always make me a drink." Another person said, "They [the staff] make me a sandwich and leave a drink."

The staff we spoke with told us they were aware of the importance of supporting people to eat and drink sufficient amounts for their needs. They confirmed that they encouraged people where necessary and reported any concerns to the office staff who would then contact the person's GP to alert them of the concern. Staff also showed a good knowledge of how to meet people's dietary needs where people had specialist diets such as those with swallowing difficulties or who were diabetic.

All of the staff we spoke with demonstrated to us that they had a good understanding of the different types of healthcare professionals who could be contacted to help people maintain good health. These included an optician, district nurse, GP or occupational therapist. We saw evidence in some people's care records that staff had contacted a GP or district nurse when they had been concerned about the person's health. We were therefore satisfied that staff supported people to maintain their health.

Good

Is the service caring?

Our findings

The people and relatives we spoke with told us that the staff were kind, caring and compassionate. One person said, "Yes they [the staff] are very good, I look forward to them coming." A relative told us, "My family member is very happy."

The service had received a number of compliments over the last two months from people they provided care to or their relatives. The compliments included comments such as , 'Fantastic carers', 'Went above and beyond the support required,' 'Fantastic carers always smiling and giggling,' 'Carers all very good at their job,' and 'I have never seen my father look so good.'

People and their relatives told us that the staff knew them well. One relative said, "[Family member says they have a good relationship with most of the carers." One person told us, "Yes, they [the staff] know me well."

The staff we spoke with told us that in the main, they were able to provide consistent care to people but that on occasions, they were asked to provide care to people they were not familiar with. From the care records we checked, we saw that people were receiving care from several different staff but that this had improved recently. The registered manager told us they did their best to send the same staff to people so they could develop good relationships with the people they cared for.

The people and relatives we spoke with told us that they or their family member were treated with dignity and respect. One person told us, "They [the staff] are very nice and I never feel unhappy with how they treat me." Another person said, "They always respect me and ask me before they help me."

The staff we spoke with were able to tell us how they protected people's privacy and dignity when they provided them with care. They explained how they made sure that any curtains and doors were closed and that people were covered whilst receiving personal care. Staff also told us that they encouraged people to be as independent as they could. They did this by supporting people to prepare their own food or drink and with their personal care needs. One person told us, "They [the staff] let me do as much as I can for myself. I prefer that."

People were involved in making decisions about their care. They and their relative if required, had been asked how they wanted to be cared for during the initial assessment of their individual needs when they started to use the service. This was completed by a member of staff who visited the person to understand what care they required. The assessment covered people's care needs and people had also set individual goals for themselves and stated how they would like their care to be delivered. One person told us, "They [the staff] do what I want them to, that's alright with me."

Requires Improvement

Is the service responsive?

Our findings

The people we spoke with and their relatives were, in the main, happy that care was provided to meet their individual needs. However, six people said that the staff did not always arrive on time to meet their individual preference. One person told us, "I never know when they are coming, but am always grateful to see them when they do." Another said, "When they arrive can vary, but usually within half an hour to an hour". A third person said, "Do you know when they are coming?"

We asked people if they had a preference regarding the gender of carer they had providing them with care. Three people could remember being asked if they wanted a male or female carer, but all of the other people and relatives we spoke with couldn't. One person said, "I've only had ladies to provide me with care." They confirmed they were happy with this. A relative said, "My relative would prefer a female carer but I don't think it's been an issue."

People's preferences in relation to the time they wanted to receive their care had in most cases, been determined. However, two of the five records we looked at in detail showed that the staff were not arriving regularly at the agreed time. The registered manager was aware that on occasions, staff could not always arrive on time. In response to this, they had reminded staff in staff meetings the importance of contacting the office if they were running late so they could pass this message on to the person concerned.

An assessment of people's individual needs had been conducted before people used the service. This was completed by a member of staff who visited the person to determine what care they required. The care records we looked at provided clear information about people's care needs and included areas such as allergies, personal care, cultural needs, the person's life history and their hobbies. From this needs assessment, a support plan had been developed. This provided staff with guidance on what care they needed to support the person with. Although we saw that in most cases the information within the support plans was detailed, they lacked guidance regarding some specific care needs.

For example, two people required assistance to care for their catheter and another with a stoma bag. There was no specific guidance for staff to follow in relation to how to meet these needs. We also found that there was nothing in people's care records detailing how staff should support people to make decisions about their care if they were unable to do this for themselves. Although the staff we spoke with could tell us how to meet these types of care needs, it is important to have clear information within a person's care record. This is so that if a staff member who is not familiar with the person's needs is required to provide care, they have clear guidance of what they need to do to meet the person's individual needs safely and effectively. The regional quality and compliance manager told us that the provider was currently in the process of agreeing improvements they needed to make to people's care records.

We have concluded therefore, that improvements are required to ensure that people's preferences are always assessed and met where possible. Clear information within people's care records was needed to guide staff on how to meet specific care needs such as stoma and catheter care.

The staff we spoke with told us that any change in people's care needs were communicated to them in a timely way. This included if people had returned from hospital and if they needed more care. The information was communicated to them via the staff working in the office or during team meetings that they held regularly to discuss the needs of the people they cared for. They also told us that people's care records reflected the care that people needed, were up to date and easy to follow.

The registered manager told us that they were aware that some people who they provided a service to were socially isolated. In response to this, they had attempted to work with a national charity to open a dementia café within the local area. Unfortunately, it had not been well attended but plans were in place to re-launch this initiative. A day centre at the service's office was also to be trialled. Letters had been sent out to people who used the service to gain their views on whether this was something they would be interested in.

All of the people spoken with said they had no complaints about the care they received. One person said, "I would recommend it." Another told us, "I'd ring the office if I had any concerns." A relative sad, "A document tells you who to contact if you have any complaints in the file."

We saw that any concerns raised had been investigated and comprehensive responses had been sent back to the complainants. We were therefore satisfied that people's complaints were taken seriously and were dealt with appropriately.

Good

Is the service well-led?

Our findings

The people and relatives we spoke with were in general, happy with the care and support they received from the service.

The staff we spoke with told us they felt supported in their jobs and understood their individual roles and responsibilities. They felt the registered manager led the service well and that they were approachable. They said their morale was good and that they all worked well as a team to deliver quality care.

The staff added they could raise any concerns with the registered manager without fear of recrimination and were confident that actions would be taken in response to these concerns. The people we spoke with echoed this. This demonstrated an open culture where people and staff felt able to voice their opinions about the care being provided.

The staff told us they felt listened to. One staff member who was new to the service told us how they had raised an idea to improve the training of new staff. This had been considered and implemented across all of the provider's services. The staff also told us they felt valued. They said that if a person or relative contacted the office to thank the service for the care received, that this information was passed onto them.

People and staff were asked for their opinion on the service provided. This was completed by both a telephone call and an annual quality survey being sent to the person's home. Any feedback received had been analysed and action taken where any improvements had been identified. People and their relatives were also asked for their opinion on the care they received during reviews of the care they received which happened once a year.

Audits of people's medicine and daily care records were completed to make sure that these indicated that people had received their medicines as they should have done and that staff had provided the required level of care. The completion of staff training and supervision was also monitored. Where any shortfalls had been identified, action had been taken to correct this. For example, we saw where staff had not completed people's medicines records a letter was issued to the staff member. If their practice did not improve, then they received re-training.

Audits were also conducted by the provider's regional quality and compliance manager. The last audit had been completed in November 2015. We saw that some issues in relation to medicines management and staff providing care prior to receiving the required number of character references had been identified. Actions had been taken to improve these areas of care. For example, the registered manager told us that people's medicine records should be audited each month but that due to the resignation of the medication officer, this had not historically occurred. We saw this to be the case with some medicine records from August 2015 not being audited until February 2016. However, support was now being provided by a medication officer from another of the provider's branches until a new officer could be recruited.

Staff practice was monitored regularly. This was completed by service managers conducting 'spot checks'

and 'work based observations' of their care practice. This formed part of the staff's supervision and these covered areas such as personal care, infection control, food hygiene, dignity and respect and medicine management.

The registered manager told us they had developed good relationships with the local GPs and other community healthcare professionals to enable them to provide a good standard of care to people within the local area. The staff also involved themselves in raising money for local charities by having coffee mornings with the service's office.

The provider looked for ways to improve the quality of care that was being provided to people. The regional quality and compliance officer told us the provider had plans in place to make the care provided more aligned to people's individual goals to help enhance their independence and wellbeing. This improvement was currently being discussed by the provider.

Another improvement being discussed was in relation to a local risk register being held within the office. This risk register would provide staff with an overview of very vulnerable people to whom they were providing care. The aim of this was to help the office staff share key information with other interested parties if needed to help keep people safe. This was being implemented in response to an incident that had occurred in the past. This had involved a vulnerable person coming to harm because a number of agencies had not communicated with each other effectively about their care needs.