First Choice Home Care Ltd

First Choice Homecare

Inspection report

42a Mere Street
Diss
Norfolk
IP22 4AG

Tel: 01379741116
Website: www.firstchoicehomecare.co.uk

Date of inspection visit:
27 September 2016

Date of publication:
21 October 2016

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

First Choice Homecare is a domiciliary care agency which provides care and support to people. At the time of this inspection care was provided to 49 people living at home. The agency looks after people living in the town of Diss and Norfolk villages.

This comprehensive inspection took place on 27 September 2016 and was announced. It was carried out by one inspector.

The provider is required, as part of their registration, to have a registered manager. 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. A registered manager was not in post at the time of our visit. The provider was in the process of recruiting a manager to comply with the requirement part of their registration.

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 agency. 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 and nutritional needs were met.

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. The provider was aware of the actions to take if a person required a DoLS application to be made.

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

People were treated by kind staff. The provider was aware of the need to improve how people and their relatives were to be more involved in the review of their or family members' individual care plans.

Care was provided based on people's individual needs. The provider was taking action to improve staff punctuality. Work was also in progress to ensure that staff stayed the duration of people's planned care visits. There was a process in place so that people's concerns and complaints were listened to and these were acted upon.

There were interim management arrangements in place pending the successful appointment of a manager. There was a team of senior staff who supported care staff to look after people. 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, 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.

People's individual needs were met by sufficient numbers of staff.

People were kept safe as there were recruitment systems in place. This was so that only suitable staff looked after people.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

People were able to make informed decisions about how they wanted to be looked after on a day-to-day basis.

Staff were trained and supported to enable them to meet people's individual needs.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by kind and attentive staff.

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

People were involved and included in making decisions about how they wanted to be looked after.

Is the service responsive?

Good

The service was responsive.

People's individual needs were met. Action was being taken to ensure that staff were punctual and stayed the duration in line with people's planned care.

People's planned care and risk assessments were recorded and subject to reviews.

The provider had a complaints procedure in place which enabled people and their relatives to raise concerns.

Is the service well-led?

Good

The service was well-led.

People were enabled to make suggestions to improve the quality of their care. Action was being taken to improve how this was being done.

The provider operated an open culture in the management of the service.

Quality assurance systems were in place which ensured that people were being looked after in a safe way.

First Choice 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 agency, and to provide a rating for the agency under the Care Act 2014.

This inspection took place on 27 September 2016 and was announced. It was carried out by one inspector.

The provider was given 24 hours' notice because the location provides a domicillary care agency; 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 any 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 agency, what the agency does well and improvements they plan to make.

Prior to the inspection we sent out 48 surveys to people who used the agency and received 22 of these completed surveys returned. We sent out 48 surveys to people's relatives or friends and received six of these. Out of the 45 staff surveys sent 13 were completed and returned. Finally, we sent out six surveys to community professionals and received one of these.

During the inspection we visited the agency office where we spoke with two directors; an interim manager; the deputy manager and the care co-ordinator. We spoke also with five members of care staff, three people's relatives and five people who were using the agency.

We looked at four people's care records; audits; minutes of staff meetings and records in relation to the management of staff.

Good

Is the service safe?

Our findings

We checked and found that arrangements were in place to keep people safe. All of the returned surveys told us that people were kept safe from the risk of harm. People and relatives told us that they felt safe because of how they were being treated. One person told us that staff members were "absolutely lovely." Another person added that they, too, felt safe. This was because the staff always made sure they wore their alarm call pendant to use in case of the need to make a request for assistance.

Staff members were aware of their roles and responsibilities in keeping people safe. They were trained and were able to demonstrate their knowledge by describing different types of harm. In addition they were able to tell us the signs and symptoms to be aware of. One member of care staff said, "You would see bruises. With regular clients [people who use the agency] you get to know them and the family circumstances. How they communicate with others [relatives/spouses]." They told us that, from this knowledge, they would know of any change in the person's behaviour, if they were being harmed. Another member of care staff said, "There would be a change in the way they [person] usually are. Or bruising." The provider had demonstrated that they followed correct safeguarding reporting procedures. This was when they notified us of what action they had taken to minimise the level of harm that people might have been experiencing. This included, for example, improving a relative's moving and handling practices when caring for their family member.

There were recruitment systems in place to ensure that people were looked after by suitable staff. One member of staff described their experience of when they were recruited. They said, "I had my C.V. [curriculum vitae]. A DBS [Disclosure and Barring Service police check]. References – I think it was two. Attended an interview." Another member of care staff also told us about their similar recruitment experience. Both staff members confirmed that their recruitment checks were completed before they started work.

We found that there were enough staff to meet people's needs. The care co-ordinator told us that there had been no recent missed calls. The record of these showed that the last missed calls took place in May 2016. However, this was due to an omission of computer information, rather than a lack of staff. The care co-ordinator said that remedial action was taken. They continued, "People's needs are being covered but I would say we are still a bit slightly short [on staffing numbers.]" They and the deputy manager both told us that they also worked as members of care staff if needed. One relative told us about an occasion when their family member needed extra help. They said, "It was a bank holiday. I had to ring for extra help and they [provider] fitted someone [care staff member] in within an hour." One member of care staff said, "Sometimes I have rung up in the afternoon to see if anyone [care staff] needs extra help." Members of care staff told us that there were always two staff members to carry out moving and handling techniques by means of a hoist. One person told us that they needed help to transfer in and out of bed. They said that this was by means of a hoist and "always" with help from two members of care staff.

One member of care staff said that difficulties arose during weekends or when staff were absent. The care co-ordinator told us that staff absences were being managed. They said, "There is a back-to-work interview.

If we recognise a pattern of sickness we invite them [staff member] in to discuss it. To see if there is a genuine reason. The manager would use the disciplinary procedure if needed." Minutes of a staff meeting read, "Back-to-work interviews; sickness [levels] have dropped." One of the directors confirmed that the provider's disciplinary procedure would be used if there were grounds to do so.

Some members of care staff told us that the scheduling of their work suggested that there might not be enough staff to look after people. However, the care co-ordinator told us that work was in progress to organise how staff worked, rather than a staffing numbers issue. This took into account where people lived and matched this against travelling time for staff between people's homes. One member of care staff said, "Travelling time is an issue. But it has got better." Another member of care staff told us that travelling time was an issue. However, they added, "It was always the case. But it's getting better. And the rosters are now changing a bit." They told us that these changes were in relation to working predominantly in one geographical area to reduce travelling time.

People were kept safe as far as possible as their risks were assessed and managed. The deputy manager told us that they visited people at home. This was to assess their individual risks which included those associated with falls. One relative told us that the care staff made sure that their family member, who was at risk of falling, always used their frame when walking about. One member of care staff described how they supported people who were at risk of falling. They said, "I help sit the person on the edge of their bed. Check if they are okay before they stand up. And ask them if they would like to proceed." Measures to reduce the risk of people falling included the use of moving and handling equipment. This was operated by sufficient staff numbers who were trained in safe moving and handling techniques.

The deputy manager told us that risks associated with people's premises were assessed and measures were in place to minimise the risks. People's care records detailed this information for the guidance of staff. For example, people's risk of security of their home was assessed. One person told us that care staff always made sure their door was locked. One member of care staff described how they 'scrambled' the codes to people's door key safes. They said, "You always have to change the key code for safety reasons." This was so that no unauthorised person would be able to gain access to the keys. Other risks included access to and from people's property, and a visual check to ensure that electricity and lighting were safe from hazards.

We checked and found that people's management of their prescribed medicines was of a safe and satisfactory standard. One person told us that members of care staff applied their prescribed creams daily. They said, "It is wonderful. They [care staff] rub some gel in my lumbar [lower back] region and calves." Another person told us that the staff members would remind them if they had forgotten to take their medicines. Medicines administration records (MARs) showed that people were given their medicines as prescribed. However, we found that the amount of tablets of variable doses (that is one or two) given had not been recorded on one person's MARs. This posed a risk of people being given under or over the prescribed amount due to the lack of completed records. Care records detailed who was responsible for ordering people's medicines. This was to ensure that people did not run out of a supply of their prescribed medicines. Members of care staff were trained and assessed to be competent in supporting people to take their medicines.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in registered services are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the agency was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the time of our visit the directors told us that no one was subject to an authorised DoLS. The manager was aware of who to contact in the event of a person requiring a DoLS application to the Court of Protection. This was by contacting the appropriate authorities to advise them about a person's mental health needs. Members of care staff had an awareness of the MCA and protecting people's rights. One member of care staff said, "[The MCA] is to determine whether a person can make a decision. Best interest is to ensure people have the care to protect their welfare." Mental capacity assessments demonstrated that people were able to make decisions about their day-to-day care.

Staff were trained to provide people with the care that they needed. In their surveys people told us that they considered that staff had the skills and knowledge to effectively meet their needs. In one person's survey we read, "Care workers [care staff] are excellent." Staff members told us that there was induction training. This included training, for example, in moving and handling; medicines management and emergency care. One member of care staff demonstrated their knowledge in responding to an emergency. They described how they would place the person into the recovery position and calling 999. Notifications showed that staff were aware of the correct actions to take in the event of a person injuring them self. This action included contacting the emergency services to assist following such incidents.

Induction training included new staff watching more experienced staff at work. One member of care staff said, "I 'shadowed' more experienced staff. The first day was meeting different people [who use the service and relatives]. It also gave you an in-depth knowledge about how the company [registered provider] works. Such as paperwork and training." Another member of care staff told us that, as part of their induction, they were progressing through a nationally recognised training programme, The Care Certificate. They told us that the training modules included the application of the MCA and safeguarding people at risk. One of the directors said, "All of our new staff are doing The Care Certificate."

In addition to induction training staff received on-going training. This included training in safe moving and handling techniques and artificial feeding methods. One member of care staff said, "Because I'm not tube [artificial method of feeding and hydration] trained I don't do this. Only staff who are trained do this."

Another member of care staff told us that they supported a person with their nutritional needs by such artificial methods. They told us that they had attended training, in this care practice, by hospital based health care professionals. They were able to demonstrate satisfactorily how this they applied this specific training into their practice.

Staff were supported to do their job. One member of care staff told us in their survey, "First Choice Homecare … keep (sic) the carers well informed and up to date with regular email communication and I am very happy to work for them." Another member of staff's survey read, "[First Choice] Homecare are brilliant to work for and would recommend any of my friends to work for them." At the time of our visit we heard similar comments from staff members. One member of care staff said, "You have lots of support from [name of the care co-ordinator] and deputy manager. If you are not sure about something, you can just ring them up." Another member of care staff had similar positive comments to make. They added also that such support was available during in and out of office hours. Staff support systems included supervision during which time staff were asked about their health, wellbeing and work-related topics.

We checked and found people were helped to maintain their nutritional health. One person told us that staff "always" made their breakfast and "make sure I eat." They added that staff ensured that they had drinks in reach. The majority of people told us that they were independent, or had other help, with making their own drinks and preparing their meals.

People's choice of what they liked to eat and drink was valued and was recorded for staff guidance. One person told us, "They [staff] ask me what I want to eat." Another person said that staff knew how they liked their "tea, milk and two sugars!"

We checked to see how people's health was maintained. People and relatives told us that they were independent in making GP or health care professional appointments. In addition to this, we found that people gained benefits from the care. One person told us that the care "stops me having to go into a home." They told us that being at home was their preferred place to be.

Good

Is the service caring?

Our findings

People were looked after by kind and considerate care staff. In their surveys people had positive comments to make about how well they were looked after. One person's survey read, "There is consistency in carers provided." Another person told us in their survey that, "My carer is only here on one morning a week, but is very sweet and takes good care of me." During our visit we received similar positive comments about care staff. One person said, "They [staff] are lovely people." One relative said, "Staff are kind. [Family member] loves them [staff]. And they [staff] love [family member]."

We found that members of staff enjoyed their job of caring for people. The care co-ordinator said, "It's about making a difference to people's lives." One member of care staff said, "[My job] is to help make people's lives easier. So that they can remain at home."

We received mixed comments made in surveys. This was in relation to consistent staff. One relative wrote, "I find too many carers, in one week [any between 13 and 17] a bit disconcerting and not consistent." However, one member of staff wrote in their survey, "I like that I have regular clients to work with and build up a good relationship with and they know who is coming to visit them." Nineteen out of 22 people's surveys told us that the person received consistent care from staff who they knew. Because of these discrepancies we explored this further during our inspection visit.

One person's relative told us that their family member had a number of different staff to look after them. However, following reviews of the care provided, this issue was now resolved. They said, "Having the same care staff throughout the day, they [care staff] get to know [family member's] needs." One person told us that they had different staff members but had no concerns about this. They told us that staff read their care records, "so they know how to look after me." A member of care staff said, "I look after about six people on a regular basis. It helps them [people and relatives] immensely. Because they have learnt to trust and rely on me. They feel they are freely able to talk." Another member of care staff said, "I have the same clients [people who use the agency] most of the time. I get to know the people I see. They want stability, not strangers. [They need] to get to know carers and build up relationships." One of the directors explained that it was the provider's aim to ensure that people received the care from the same staff. However, this was not always possible due to changes in the staff team. Nevertheless, work was in progress to improve the management and rostering of staff.

In their surveys people told us that staff respected their privacy and dignity and people confirmed this during our visit. People's surveys also told us that the staff enabled them to be independent. One person's survey read, "They give me independence and are kind and caring." Staff were aware of what constitutes principles of good care and were able to demonstrate their knowledge. This included promoting people's independence with personal care. Care records detailed the level of people's independence that staff were to maintain. During personal care, people's privacy was respected. The care co-ordinator said that this was an area they would assess during unannounced 'spot checks' on members of care staff. They said, "[I check] that personal care is being carried out. This includes if a person is safe to be left when using the toilet, without being watched." They also described how they would assess if people's choices were being valued.

This was, for example, choices of what the person would like to eat and drink. Another choice preference of staff gender was recorded in people's care records. This detailed if the person preferred to have a male or female member of care staff to look after them and their preferences were respected.

Care provided was to support the main carer, such as a relative or friend. One relative told us that their family member was provided with care so that they could have a short break from being the main carer. This allowed their family member to stay living at home, in familiar surroundings, and with their relatives.

People's rights to having information was valued. This included, for example how to raise a concern or complaint and the schedule of their planned visits. The rights of people to make decisions and choices were upheld. In their surveys, people told us that they were enabled to make decisions about their planned care. During our visit people were aware of their planned care and told us that staff offered them choices about how they wanted to be looked after. This included, for example, what they wanted to eat and drink.

Good

Is the service responsive?

Our findings

In their surveys people told us that staff were punctual and stayed the duration of their allocated time. However, just less than half of the relatives' surveys agreed with this statement. Because of this discrepancy we explored this further during our inspection visit and found mixed comments about this. One relative said, "At first it was hit and miss. But now staff know where we live, there is no longer a problem." One person told us that staff were always punctual. Another person said that, although the staff arrived on time, they did not always stay as long as they should. One relative told us that, on the morning of our visit, the member of care staff arrived 20 minutes late. Another relative told us that the member of care staff was 25 minutes late and this was "frequent." One member of care staff said, "For today, my time sheet showed that I was to start at 8:30 and finish [call visit] at 9:00. But then I was to start at another person's house at 9:00. Luckily it was only six minutes away."

The provider was aware of the remedial action to be taken and work was in progress to improve how people's needs were met. The care co-coordinator said, "Recently I have changed the runs [scheduled visits, including travelling time]. I've split the runs to allow for travelling time." One of the directors advised us that, during October 2016, an electronic monitoring system would be used. This was to monitor the times of when staff arrived at people's homes and when they left. This showed that most of the time people's needs were being met. It also told us that the provider was taking action to improve how and when people's needs were being met.

Before people started to have the care provided by the agency, their needs were assessed and recorded. This was to ensure that the agency was a suitable and appropriate provider. One relative told us that they were involved in setting up their family member's care plan. People's care records contained information about the care required to meet people's needs. One relative said, "It's [information] all in the care plan for them [care staff] to look at." Another relative said, "Staff get [family member's] file [care plan] out to see what is happening and put their comments in every day."

We checked and found that information about people's life histories was recorded. This was so that people were seen as unique individuals. People said that they felt staff, who were regular, knew them as individuals. Social care activities were not yet provided. However, the deputy manager and one of the directors told us that plans were in place to introduce this type of care during October 2016.

People's individual needs were assessed and kept under review to ensure that the care was appropriate to their needs. One person told us that their planned care had been reviewed. However, one person's relative told us that their family member's planned care was yet to be reviewed. Nevertheless, they and other people said that they were satisfied with how the care was meeting people's individual needs.

In their surveys all of the people told us that they knew who they would speak with if they were unhappy about how they were being looked after. The surveys also told us that when people raised any concerns, they were satisfied how the provider responded to these. Members of care staff knew how to support people with raising a complaint. This included following the provider's complaints procedure. People were

provided with such information in the service user's guide which detailed contact details of external agencies, such as the local authority. One of the directors advised us that people received this document when they were due to start receiving their care.

The community professional told us in their survey how the management of the agency had taken action in response to a complaint of theirs. This was to reduce the number of missed calls. The deputy manager described the complaints procedure, which included an investigation into the concerns raised. Information obtained from notifications demonstrated that the provider took people's complaints seriously. They investigated with the aim to resolve people's complaints to their satisfaction. The deputy manager described the complaints procedure, which included an investigation into the concerns raised. This included, for instance, reminding staff to respect confidential information. Other remedial actions included aiming to improve both staff punctuality and continuity of people's care.

Good

Is the service well-led?

Our findings

A manager was not in post at the time of our visit. Interim management arrangements were in place pending the successful appointment of a replacement manager. One of the directors said, "We have two people [candidates] who are highly qualified and experienced." They told us that the candidates were undergoing an interview process before, "We make a decision from there." The director gave us assurances that, as the agency was without a registered manager in excess of 300 days, an application to register the appointed manager would be made without delay.

In their surveys people told us that they knew who to contact in the agency. However, one relative wrote, "We are not notified when call times permanently change." During our visit relatives said that they had not been notified of any delays in staff arriving at the scheduled time. One member of care staff told us that they would ring the office staff if they were not able to comply with their schedule. They said it was their understanding that the office staff were responsible in telephoning people, or their relatives, in the event of delays or changes to their planned care. This told us that communication improvements were needed to ensure that people were kept informed.

Information people provided in their surveys told us that the provider obtained people's views about their care. However, this was not the case for all of the respondents. Because of this discrepancy we explored this further during our inspection visit. One relative said, "Initially someone [from the agency] came out and asked some questions and I was involved in that." Another relative told us that they, who represented their family member, had not been asked for their views about their family member's care. In one out of four people's care records we found recorded evidence that the person was asked for their views about their care. However, the manager told us that an audit was carried out which identified this issue. An action plan was being developed to improve this deficiency. They said, "The deputy manager with the care co-ordinator will carry out reviews. This will be monthly telephone calls." One member of care staff told us that during 'spot checks' their observer asked people for their views about how well they were being looked after.

The provider operated an inclusive culture. Staff were enabled to make suggestions and comments during meetings. One part of the staff meeting minutes read, "Team feedback is needed as it is really important that we know what carers think…" Minutes of these demonstrated staff making suggestions to improve their working conditions. These included, for example, travelling time being taken into account as part of their work schedule. In addition to these methods of obtaining feedback and suggestions, people and their relatives were provided with opportunities to share their views in a survey. The results of these were collated and analysed during January 2016. Quality assurance systems were used to improve any less than positive comments made by respondents. This included, for example, the provider had set out to improve, and was improving, staff punctuality.

Unannounced 'spot checks' were used to assess if staff were providing people with the care to safely meet their needs. The care co-ordinator told us that they checked the punctuality of staff members. They also checked if the staff member was complying with the provider's uniform and infection control policies. One member of care staff told us that they were observed for these things. They also added that they were given

feedback but no actions were needed to improve the quality and safety of their work. This showed that staff at work were monitored to ensure people were having their care as planned.

The provider operated an open culture. This was because there was a whistle blowing policy in place. Members of staff were aware of when they would use this policy. They said that they would have no reservations in raising concerns, about the safety of people. This would be through the provider's management channels, or to local authorities. Information in the staff survey told us that the respondents had no concerns in raising their concerns with the provider, if needed.