Sunderland Home Care Associates (20-20) Limited

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Inspection report

Elliot House
Mainsforth Terrace West
Sunderland
Tyne And Wear
SR2 8JX

Date of inspection visit:
11 July 2018
12 July 2018
16 July 2018

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30 August 2018

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

The inspection took place on 11, 12 and 16 July 2018. This is the first time we have inspected the service since it was registered in July 2017.

Sunderland Home Care Associates (20-22) is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older adults, some of whom are living with dementia. At the time of the inspection there were 167 people receiving a service.

The service had a registered manager in place. 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 and their relatives told us they felt safe receiving support from staff. Staff had completed training in safeguarding people and the service actively raised any safeguarding alerts with the local authority in a timely way.

Risks to people's safety and wellbeing were assessed and managed. Environmental risk assessments were in place in relation to people's own homes.

People's medicines were administered in accordance with best practice and managed in a safe way. There were some ongoing issues with medicines administration records and work to improve these was ongoing.

People and relatives felt there were enough staff to meet people's needs. The service used an electronic system to organise rotas and ensure enough staff were deployed to calls. Staff were recruited in a safe way with all necessary pre-employment checks carried out prior to starting work for the service.

New staff received a structured induction programme which included face-to-face training as well as shadowing shifts and assessments. All staff received regular training, supervisions and annual appraisals to support them in their roles.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

People were supported with their nutritional needs where required and to access a range of health professionals. Information of healthcare intervention was included in care records.

People and relatives felt the service was caring and staff were friendly. Staff treated people with dignity and respect when supporting them in their homes. People were supported to be as independent as possible.

People had access to advocacy services if they wished to receive support. Some people also had Lasting Power of Attorneys or relatives they appointed as advocates.

Care plans were in place for meeting each person's individual needs. They were personalised, detailed and included people's preferences. Regular reviews were carried out with people about their care and support.

People and their relatives knew how to raise any concerns they had about the service. The provider had a complaints procedure in place and kept a log of any complaints received. All complaints received were investigated, acted upon and outcomes were fed back to complainants.

There were audit systems in place to monitor the quality and safety of the service. The views of people were sought by the service via questionnaires. All results were analysed and improvements were made, where identified. Any trends and lessons learnt were also recorded and acted upon.

The service worked in partnership with a number of agencies, including the local authority, safeguarding teams and multidisciplinary teams, to ensure people received joined up care and support.

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 told us they felt safe receiving support from staff. Medicines were managed in a safe way.

Staff received training in how to safeguard people and any concerns were raised with the local authority.

There were enough staff deployed to meet people's needs. New staff were recruited in a safe way.

Is the service effective?

Good

The service was effective.

New staff completed an induction programme. All staff received regular training, supervisions and annual appraisals.

People were supported with minimum restriction and staff asked requested consent from people prior to providing support.

People were supported with their nutritional needs and had access to a range of health care professionals.

Is the service caring?

Good

The service was caring.

People told us staff were kind, chatty and caring.

Staff treated people with dignity and respect and promoted their independence.

People had access to advocacy services.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to them receiving support from the service.

People and their relatives felt involved in the ongoing planning and reviewing of their care.

People knew how to raise concerns and complaints were investigated and managed.

Is the service well-led?

Good

The service was well-led.

People and their relatives felt the service was well managed.

The provider had an effective auditing process in place to monitor the quality of service provision.

Staff attended regular meetings. The service sought feedback from people via questionnaires.

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Detailed findings

Background to this inspection

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

This comprehensive inspection took place between 11 and 16 July 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is a community based service and we needed to be sure the office would be staffed.

Inspection site visit activity started on 11 June and ended on 16 July 2018. It included a visit to the office on 11 and 16 July 2018 to see the registered manager and office staff; and to review care records and policies and procedures. We made telephone calls to staff, people and relatives on 12 July 2018.

The inspection was carried out by one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

During the inspection we spoke with seven people and three relatives. We also spoke with six members of staff, including the registered manager, the recruitment and training manager, the compliance officer, a care co-ordinator and two supervisors who also provided care and support to people. We looked at seven people's care records and seven people's medicine records. We reviewed four staff files, including records of the recruitment process. We reviewed supervision, appraisal and training records as well as records relating to the management of the service.

Before the inspection took place we reviewed the information we held about the service. This included notifications we had received from the provider. Notifications are changes, events or incidents the provider

is legally required to let us know about.

Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

As part of our inspection planning we contacted the local authority commissioners of the service, the local authority safeguarding team and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Good

Is the service safe?

Our findings

People and relatives told us people felt safe when receiving support from staff. One person said, "Yes, I do feel safe. I know what's expected and I'm happy with it." A second person told us, "Yes, I feel safe because they're very careful and obliging." Other comments included, "Absolutely safe, I look forward to them coming", "Yes (feel safe), because they come every day. They make sure I'm alright", "Yes, I do feel safe. They understand my problems and know all about me" and "Yes, I do feel safe because they're really nice carers."

Staff received regular safeguarding training to refresh their knowledge in how to identify potential signs of abuse and how to report any concerns. The registered manager had a safeguarding file in place that included a log of all safeguarding concerns identified, alerts raised to and concerns received from the safeguarding local authority, investigations and the subsequent action taken. Where necessary, alerts had also been made to the police. Records showed safeguarding concerns were investigated and outcomes communicated to the person involved, if appropriate, and all other relevant parties. The provider had safeguarding and whistleblowing policies in place and staff had access to these via their staff handbooks provided to them at the start of their employment. This meant staff had access to information to enable them to report any concerns via appropriate methods.

Risks to people's health, safety and well-being were assessed and managed. Risk assessments were stored within care files and were regularly reviewed by supervisors. All identified risks had appropriate plans of care in place which detailed how care was to be provided to reduce those risks. In addition to risk assessments around people's individual needs there were also risk assessments around the internal and external environment of people's homes. For example, limited space in the bathroom for two care workers to support a person. The measures in place to minimise potential risks were recorded. Potential escape routes and evacuation plans for people in the event of an emergency were also detailed.

Medicines were administered and managed in a safe way for those who required support. Records confirmed medicines were managed safely. We viewed the medicine administration records (MARs) for seven people. Most records were completed accurately, with staff initials to confirm medicines had been administered at the prescribed dosage and frequency. There were gaps identified in one Topical Medicine Record (TMAR) which was due to the cream being 'when required' but it wasn't clearly identified on the TMAR. We discussed this with the registered manager and they took immediate action to rectify the error.

All staff administering medicines were trained and had their competencies checked to ensure those administering medicines were safe and experienced to do so. Regular medicines audits were carried out by care co-ordinators and registered manager to identify any errors in administering or recording. There were errors identified from the medicines audits we reviewed. These were recorded, raised with staff members involved and actioned appropriately.

The service recruited staff in a safe way. Applicants completed an application form in which they set out their experience, skills and employment history. All necessary pre-employment checks were carried out for each new member of staff including two references, proof of identification and an enhanced Disclosure and

Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and minimise the risk of unsuitable people from working with children and vulnerable adults.

A care co-ordinator explained the electronic system 'Care Free' which they use to manage staff rotas and people's calls. They demonstrated how they arranged rotas and ensured all calls were allocated to staff. All care staff were issued with a work mobile phone which they used to access their individual working rotas. This meant any changes or updates to rotas were immediately available to staff. Any changes made to their rotas were communicated to them via the 'road runner' messaging service on the application.

We viewed a selection of electronic rotas to check that enough staff were deployed to calls. Each rota contained a list of carers with times of calls. The care co-ordinator explained how people had a tag attached to care plans in their home which staff scanned with their phones upon arrival and prior to leaving. This function then automatically updated the system with the date, time and duration of calls made by staff. The care co-ordinator said, "We get an alert if a carer doesn't arrive in the first 15 minutes of a call. We receive an alert so we can contact the carer to see where they are. It means there's no missed calls so it's good for safety purposes (for both people and staff)." They told us if a staff member couldn't get to the call they arranged for another staff member to attend and informed the person.

People told us there were enough staff to support them, support wasn't rushed and they received support from the same care staff. One person said, "I get the same carer every time." Another person told us, "Most of them are on time. I have the same one nearly every day except Saturday. I get the same one then. I've never had a missed call." A third person commented, "It is important to have the same people. I get the same carer every time. Always on time 99%. If not they (staff) always ring on the mobile." A fourth person said, "Yes, there is enough staff. Yes, they come on time. If I don't feel well, I just cancel. If they can't make it, they ring. I'm happy with that. I see the same carer all the times, it suits me."

The provider had an accident reporting policy in place which detailed how to record and report on any accidents in the service. The registered manager kept a record of any accidents and incidents that occurred which were monitored by the compliance officer for any potential patterns and trends. There had been two accidents that had occurred in the last 12 months. Records showed the accidents had been investigated to see if they could have been avoidable and to identify any measures that could be put in place to mitigate the risk of a recurrence. For example, installation of a handrail. There were no trends identified nor lessons to be learnt from the two accidents recorded.

Care plans included instructions to staff to promote infection control. For example, to wash hands prior to supporting people, where to dispose of incontinence aids and details of Personal Protective Equipment (PPE) practices, such as the use of disposable gloves. PPE helps prevent the spread of germs and protects people and care workers from infections.

The compliance officer ensured that information was available to staff about any relevant safety alerts received or identified lessons learnt. This information was communicated to staff through the 'road runner' instant message system included in the application on work mobiles. They also shared information in staff meetings. For example, safety alerts for recalls of medicines or frozen food products.

Good

Is the service effective?

Our findings

People told us staff knew them and their needs, including how best to support them. One person said, "The carer knows me. Yes, no bother they know me." Another person told us, "They know how I like to be looked after." A third person commented, "If I want something they do it for me. They understand my needs." A relative said, "No complaints up to now. They know if [family member] gets annoyed to give (them) the medication and just go." One person had mixed views depending on staff and felt younger staff didn't always know how to support them. We spoke with the registered manager about this who informed us that people can state their preferences with staff and request older staff if that would make them feel more comfortable. A care co-ordinator told us they ensured all staff were trained and competent before allowing them to support people in their homes.

Newly recruited staff completed a comprehensive induction prior to supporting people. The recruitment and training manager said, "They do a full week and two days induction (face-to-face). It covers everything in the care certificate, moving and handing, person centred care, food hygiene, health and safety and fire safety." Staff then went on to complete a further 12 weeks induction course to complete the Care Certificate as well as two weeks of shadow shifts inclusive of spot checks by senior staff. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

Records showed that staff regularly completed a range of training to enable them to carry out their roles effectively. Topics of training included moving and assisting, safeguarding, first aid, health and safety and food hygiene. The training and recruitment manager told us, "I attended a react to red (skin integrity) course at the University of Sunderland, it's a pilot scheme. It was assessed by a Tissue Viability Nurse (TVN). I've recently passed that so we're going to roll that training out to all staff." Staff had also completed training specific to people's needs such as Huntington's Disease and dementia. The training and recruitment manager said, "We tailor the training around people's needs. The Parkinson's Nurse is coming out in September to do some training with the staff. We also do end of life training with the hospice."

Staff received regular supervisions and annual appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. The recruitment and training manager said, "We use the 'Care free' system to monitor when staff are due their next supervision and their annual appraisal." Records of these meetings showed they were used to discuss their performance and conduct as well as training, health and safety, safeguarding, infection control, policies and procedures and outcomes of spot checks carried out. Any identified actions were recorded and revisited at the next supervision session to discuss whether they had been completed.

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

All staff had received MCA training which was up to date and guidance around seeking consent was available in care plans. Staff we spoke with demonstrated an understanding of MCA and the importance of gaining consent from people prior to providing support. Care files contained mental capacity assessments, where necessary. Assessments were decision specific, for example, staff to administer medicines. The registered manager and staff we spoke with understood the best interest decision making process and had the templates to hand if they required them. For those people who were assessed as not having mental capacity to make specific decisions best interest decisions were not made as they had relatives or friends who had Lasting Power of Attorney (LPA) and were able to make decisions on their behalf. LPA is a legal process granted through the Office of the Public Guardian that permits designated individuals to make decisions on people's behalf, if they do not have the capacity to do so.

People were supported to meet their nutritional needs, where required. One person said, "As regards meals, they know what I like. The carer will suggest things and will get me anything special that I can't get for myself." Care plans contained details of how to support people with their meals. For example, one person's care plan instructed staff to ensure their food was cut up into small pieces and to give them time between each mouthful.

People were supported to access external professionals to monitor and promote their health, where required. Care records contained evidence of collaborative working with healthcare professionals such as GP's, pharmacists and district nurses.

Care records demonstrated how a person's physical, mental and social needs were assessed when they started using the service and they were then reviewed on a regular basis. Care records contained information which considered current legislation and national guidance. For example, NHS choices information for conditions such as Dystonia and Cerebral Palsy. Dystonia is a neurological movement disorder syndrome in which sustained or repetitive muscle contractions result in twisting and repetitive movements or abnormal fixed postures.

Good

Is the service caring?

Our findings

People told us they were comfortable with staff and described the service as caring. One person said, "Yes, they are caring. They do everything I want." Another person told us, "We have a good chat when they help me to the toilet and have a good laugh." A third person commented, "(Staff are) kind and caring. Yes brilliant." A fourth person said, "The carers that comes are very, very good, just like friends."

The service provided people with a 'service user guide' when they first started using the service. The guide contained information about the provider and the service. This provided contact details, a guide to what to expect from the service and how to raise any concerns, as well as documenting how people's rights would be respected.

Staff treated people with dignity and respect. One person said, "They give me dignity and respect. They look after me really, really well." Another person told us, "They treat me well. They close the door to keep my dignity. I am comfortable and treated with respect." A third person commented, "The carers are kind and respectful, they are. They cover me up." A fourth person told us, "They treat me well. They lock the door behind them when they come in, at my request." A fifth person commented, "There is inherent respect there." Care plans included details to guide staff how to protect people's dignity. For example, one person's personal care plan instructed to cover the person with a towel prior to removing their pyjama bottoms.

People's needs had been assessed and appropriate plans of care had been implemented. We viewed people's care records and noted staff recorded daily notes in log books. Records included details of support provided to each individual as well as people's general mood and if they showed any signs of feeling unwell or had any concerns. We saw from one person's daily notes that they had mentioned to staff about their stairlift being broken. Staff contacted the stairlift company on the person's behalf, with their consent, and the person's stairlift was repaired the following day.

People were supported to be as independent as possible and their capabilities were included in their care files. For example, one person's oral hygiene care plan stated, "Put toothpaste on brush and hand to [person] to brush his teeth." Another person's personal hygiene care plan stated, "Carers to pass the appropriate flannel and [person] will wash/dry their lower body independently but may require support to wash/dry her feet."

Most people receiving support from the service could express their own views and opinions about their care and about the service in general. Where necessary, relatives or Lasting Power of Attorney acted on behalf of people. The registered manager told us at the time of the inspection that no one was actively receiving support from an advocacy service. Advocates help to ensure that people's views and preferences are heard. Information relating to different advocacy services and how they could assist people was also detailed in the provider's 'service user guide.'

All files containing confidential information including people's care plans, archived records and staff files were securely stored in locked cabinets in a secure office at the registered location. All computers and work

mobile phones were encrypted with passwords. The registered manager told us a mobile phone could be remotely wiped and locked if it went missing to ensure confidential information wasn't accessible. This meant people's private information was stored securely and confidentiality was maintained.

Good

Is the service responsive?

Our findings

People had their needs assessed prior to receiving care and support. Assessments were used to gather personal information about people to help care co-ordinators understand their needs and to inform plans of care. Information gathered included life history, cultural and spiritual needs, emergency contacts and health professionals involved. Assessments also included medical conditions, sensory, physical and cognitive needs.

People and relatives told us they were involved in planning their care and making decisions. One person said, "Yes, I have a care plan. My husband and I are involved." Another person told us, "Yes, I am involved in care planning. I have identified my own needs." A third person commented, "Oh yes. I have a say and they do everything as I want. They leave it as it is which is what I want." A fourth person said, "I know what I need, and the carers know what I need."

People had care plans in place to meet their needs identified in their assessments. Care plans were detailed and contained people's choices and preferences. Care records we viewed were personalised and reflective of people's individual needs. They also included daily routines for people which detailed how staff were to support people from the point of arriving at a person's home and how to enter their property to providing all support and leaving. For example, one person's care plan stated, "To gain entry to the building use fob from key safe and return fob to key safe straight away. To gain entry to (person's) flat use key from key safe outside of flat door. Call to [person] and check he is okay. [Person] is normally very sleepy on a morning."

Care plans we looked at had been reviewed on a regular basis and updated when required, in line with people's changing needs. People felt in control of their care and were involved in care plan reviews. One person said, "Yes, there are care plan reviews. Mine stays as it is at the moment." Another person told us, "Mine stays the same because that's what I need." A third person commented, "Yes, I am part of the decision making at care reviews. I have choices but I'm quite happy with the care I've got."

People and relatives were asked if they were happy with the service or if they had any concerns. Everyone spoke positively about the service and told us they had no concerns. One relative said, "Never (needed to complain), no." The provider had an up-to-date complaints procedure in place which was included in service user guide given to people when they started using the service. The registered manager maintained a file of all complaints received. Records showed the service had received one complaint in the last 12 months. The complaint had been acknowledged upon receipt and investigated by the registered manager. The complaint was actioned appropriately, in accordance with the provider's complaints procedure.

At the time of the inspection no one was receiving end-of-life or palliative care. Care files contained end-of-life plans which recorded any wishes people had expressed. For example, wishing to remain in their own home. They also included whether people had made any advanced decisions. People were provided with a 'Let's Talk About it' leaflet which gave information about end-of-life and plans for that time. Care files also indicated if people did not wish to discuss this topic. Staff received training in end-of-life care through distance learning as well as through the local hospice.

Good

Is the service well-led?

Our findings

People and their relatives told us they felt the service was well managed. One person said, "They all work well together. One of the managers used to do my care when anyone was off. Is approachable. I am overall happy with my care." Another person told us, "I hope there's no change I don't think it could be improved." A third person commented, "The service is very good." Other people told us they were "happy" with the service they received. A relative said, "They work as a team. There is no animosity. The manager is brilliant and understanding of my [family member]. I couldn't speak more highly of them". Another relative told us, "The service is excellent."

The service had an established registered manager who had been registered since July 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The registered manager clearly understood their responsibilities and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Care Quality Commission by law.

We received positive feedback from people regarding management. One person said, "The manager is very, very approachable." A second person told us, "I have met the manager. She's very efficient, kind, knowledgeable. The right person in the right job." A third person commented, "The manager is approachable."

The service used a number of methods to communicate with staff including the instant messaging 'road runner' system, memos and newsletters. The registered manager told us, "We have an open-door policy as well. Staff come in whenever they want to see us. Usually a Monday is a busy day. They also come in for gloves and things as well (so can speak to management then too if needed)."

During the inspection we asked for a wide variety of records and documents from the registered manager and other staff. We found records were easily accessible, stored securely and well maintained. Throughout our inspection we found the registered manager and staff to be open, approachable and cooperative when we spoke with them.

The service had out-of-hours arrangements in place to ensure staff members were able to contact a member of the management team if needed. The care co-ordinator said, "We do the out-of-hours cover on an evening and a weekend." The recruitment and training manager told us, "Calls come through the office during the day and through to the on-call phone outside of hours which is manned by the care co-ordinators." The allocated senior person covering the on-call had office phones diverted to them and had an iPad with remote access so they could access electronic records such as staff rotas and people's care needs.

The registered manager and compliance officer completed a number of audits to check the quality and safety of the service. These included medicines management, daily records/logbooks, safeguarding concerns and complaints. All findings were recorded as well as any required actions. During the inspection we saw that actions had been completed and signed off where identified. Audits were also used to identify

any trends or potential lessons learnt. For example, to use clear plastic NOMAD systems for medicines in future to improve medicines management. A NOMAD system is a method of dispensing medicines in a pre-packed form to help people keep track of what to take and when to take it.

Monthly medicines audits had identified ongoing recording issues. The registered manager and compliance manager informed us they had appointed a medicines champion as a result of this who completed all medicines audits. They also held sessions with specific staff members who were identified as making the recording errors. We saw minutes of sessions with staff members which included how to complete records accurately and the importance in doing so. The registered manager told us they were working with staff to improve recording and were planning to introduce a key worker type role for people, who would be responsible for ensuring Medicines Administration Records (MARs) were updated when the person started taking new medicines. They also informed us that, following sessions with the medicines champion, if staff continued to make errors, they would follow their disciplinary procedure.

Regular meetings took place between office and care staff to discuss all aspects of the service. We reviewed minutes of meetings which showed discussions included MAR chart audits, log books, rotas and communication systems. Minutes reflected staff being involved in discussions and providing input and feedback into meetings.

People were asked for their views via an annual questionnaire. One person said, "I have filled in questionnaires and they have listened." Another person told us, "I've had questionnaires, but I don't see how they can improve the service." The compliance officer collated and analysed the feedback received with the registered manager and created a summary of findings, comments and any identified improvements. Feedback received was mostly positive with overall satisfaction levels being mainly 'Very High' or 'Very Satisfied' with none less than 'Satisfactory'.

As part of the care plan review process, supervisors also completed a monitoring and quality assurance questionnaire with people, and their relatives if they wished to be present. Areas covered included if they had written information about the service to be provided to them. It also asked if they were happy with the service, if their privacy and dignity were respected, if they felt staff were adequately trained and if they received continuity of care staff. There were no issues or concerns raised or suggested improvements recorded in the questionnaires we reviewed.

The service had received five compliments in the form of 'thank you' cards, letters and emails in the last 12 months from relatives of people who had used the service. Comments included, staff whose "care restored our faith in the care services," "wonderful home care and companionship," "expert care," "wonderful carers who really have been truly caring", and staff "are a credit to your organisation."

We saw the service worked in partnership with a number of agencies, including the local authority, safeguarding teams and multidisciplinary teams, to ensure people received joined up care and support. The registered manager kept up-to-date with relevant changes, and had effective systems in place to cascade the information to all staff.