Heron Care Limited

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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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection visit took place on 30 November 2018 and was announced.

Heron Care Limited also is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. Not everyone using Heron Care Limited receives a regulated activity. Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

Majority of the people supported by this service live in their own homes. However, the service also supported people who lived in a supported living set up. There were 85 people using the service at the time of our inspection.

At our last inspection in April 2016 we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. Any concerns that had been raised had been adequately responded to ensure people's safety. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection

The registered manager had systems in place to record safeguarding concerns, accidents and incidents and take appropriate action when required. They had responded adequately to safeguarding concerns raised by people and professionals. Recruitment checks were carried out to ensure suitable people were employed to work at the service.

Staff skills, knowledge, training and support demonstrated a commitment to providing good standards of care that were embedded into the practices of the staff and the management team. Improvements were required to ensure staff received supervision in line with the organisation's policy. The registered manager took consideration of people's views.

Risk assessments had been developed to minimise the potential risk of harm to people who used the service. These had been kept under review and were relevant to the care and support people required.

Care plans were in place detailing how people wished to be supported. People who received support, or where appropriate their relatives, were involved in decisions and consented to their care. However, improvements were required to the process for assessing mental capacity. We found mental capacity assessments had not been completed to demonstrate how decisions had been reached about people's ability to make decisions about receiving care. We asked the registered manager to address this and made a recommendation about the assessment of people's mental capacity. People's independence and choice was promoted.

Staff responsible for assisting people with their medicines had received training to ensure they had the competency and skills required. People told us their medicines were safely managed.

We found people had been assisted to have access to healthcare professionals and their healthcare needs were met and reviewed regularly. People's independence was promoted, and staff ensured people remained active members of their local community.

People who used the service and their relatives knew how to raise a concern or to make a complaint. The complaints procedure was available, and people said they were encouraged to raise concerns and complaints had been addressed. Staff had received compliments from people's relatives.

The majority of the feedback we received from staff and people who used the service was positive. However, we also received mixed feedback from two staff members and two people about the way care visits were arranged, management and staff competences. We shared the views with the registered manager.

The registered manager used a variety of methods to assess and monitor the quality of service provided to people. These included regular internal audits of the service, surveys and staff meetings to seek their views about the quality of care they provided and their job.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? This service remains good.	**Good**
Is the service effective? This service remains good.	**Good**
Is the service caring? This service remains good.	**Good**
Is the service responsive? This service remains good.	**Good**
Is the service well-led? This service remains good.	**Good**

Heron Care Limited

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 30 November 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is domiciliary care service and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection team consisted of one adult social care inspector and an expert by experience, who had experience of caring for older adults.
Before our inspection visit we reviewed the information we held on the service. This included notifications we had received from the provider about incidents that affect the health, safety and welfare of people who used the service. We also reviewed the Provider Information Return (PIR) we received prior to our inspection. 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 provided us with information and numerical data about the operation of the service.

Before the inspection, we had been made aware of safeguarding concerns that had been investigated by the local authority's safeguarding team and complaints that had been made about the service. Some of these safeguarding concerns had been substantiated and a complaint had been upheld by the local authority. As a result, this inspection did not examine the circumstances of the concerns. However, the outcomes shared indicated potential concerns around the way visits were planned and staff competence in relation to moving and handling people. This inspection examined these areas.

We spoke to 10 people who used the service and two people who had left the service via telephone interviews. We also spoke to seven staff members over the phone and received feedback from three care staff via emails. We spoke with the operations manager, the training manager, a care manager, one administration officer and the registered manager who is also the owner.
We looked at care records of four people, training records for all staff, records of staff visits, three

recruitment records of staff members and records relating to the management of the service. We also contacted the safeguarding and contracts monitoring departments at the local authority.

Good

Is the service safe?

Our findings

The majority of people told us they felt safe receiving support from Heron Care Limited because they trusted the staff that supported them. In a recent safeguarding survey by the provider, people expressed that they felt safe. Comments from individuals who used the service included, "When I fell out of my wheelchair, the carers found me and stayed with me until the paramedics arrived I knew I was extremely safe in their hands, they helped to calm me down as I was very anxious", "They use the key to get into my home, that is the arrangement we made with them, I am not uncomfortable with them having the key as I know they will keep it safe." However, we also received mixed feedback from two people who had left the service. They informed us they had left due to concerns in relation to staff's competence in using hoisting equipment and inconsistences in the way visiting times were arranged.

We spoke to the registered manager regarding these concerns and they informed us that the concerns had been addressed. The service had purchased a hoist that was used to re-train staff and check their competence. They also informed us that they had employed a quality assurance officer and increased the frequency of seeking people's views regarding care visits to capture any shortfalls in the way visits were conducted.

Eight people told us they had good working relationships with care staff which enabled them to communicate honestly and without fear of repercussions and this was evident in our discussions with people.

There were procedures in place to minimise the potential risk of abuse or unsafe care. These had been reviewed since the last inspection and training continued to be updated for staff. In addition, staff had been recruited safely, appropriately trained and supported by the management team and external specialist professionals where required.

Risks to people were assessed and their safety was monitored and managed so they were supported to stay safe and their freedom respected. Before the inspection there had been concerns that people's, risks had not been adequately assessed and that risk assessment were not in place for some people. However, when this was brought to the registered provider's attention, they took a proactive approach to address this. We found in all records we checked, processes for risk assessments had been reviewed. The provider's risk management policies and procedures showed the ethos of the service was to support people to have as much freedom of choice in their lives as possible. Policies and procedures were in place to ensure people's security was not compromised where staff had access to key safes. A key safe is a secure way of safe keeping people's house keys within their property.

The care plans we reviewed had risk assessments completed to identify the potential risk of accidents and harm to staff and the people in their care. The risk assessments we saw provided instructions for staff members when delivering support. Where potential risks had been identified, the action taken by the service had been recorded. This included general risks around people's property including trip hazards and risks associated with falls. We discussed the need to include risks associated with continual refusal of care and

risks associated with the use of medical attachments such as percutaneous endoscopic gastrostomy tube (PEG) and bedrails. A PEG is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate for example, because of dysphagia. This was because we found one of the files did not have details of the risk assessments. This had no significant impact to the quality of the care record but needed to be robust.

Before the inspection we received outcomes of safeguarding concerns that had been investigated by the local authority. Some of the concerns had been substantiated and recommendations had been made to resolve the concerns. We found the registered manager had responded to concerns and safeguarding procedures carried out and protection measures were robust and took into consideration wishes and feelings of people and their relatives. Disciplinary procedures were in place and had been followed where necessary. Information on how to report concerns was readily available. In the cases we reviewed, outcomes of safeguarding investigations had been used to improve people's outcomes and the care they received. One professional at the local authority wrote, 'The managers responded proactively to safeguarding concerns and were keen to take corrective action.' We were assured that safeguarding concerns were acted on and lesson were learnt.

The service monitored and regularly assessed staffing levels to ensure sufficient staff were available to provide the support people needed. There were systems in place to monitor staff visits to show the time of arrival and time of departure. During our inspection visit we reviewed staffing rotas and sought feedback from people and staff. We noted that care visits had been planned in advance for staff. However, some of the rotas we reviewed showed visits had been planned back to back without indication of time allocated for travelling between visits. Feedback both people and staff was mixed. Two care staff stated that they felt care visits for staff who did not drive were not arranged in a way that allowed them to have adequate time to walk from one visit to another and some distances were not walkable. Two people who had left the service, stated that staff did not always stay the duration. Another person told us they felt staffing rotas were not consistent and staff changed without notice and at times staff did not stay the duration of the visit.

Comments from eight people demonstrated that staff had visited as planned and stayed the duration of the visit. Comments included, "They come at the right times this gives me reassurance, however if they are ever late they then phone me and let me know." and, "The majority of my carers are amazing. They go above and beyond to make sure I am looked after well. I have built good relationships with them and really appreciate all they do for me. One point I would make is I don't like my carers being moved around. I need people that know me, know my routines, medications and have an understanding of my illness. I am also very uncomfortable with new staff doing my personal care." We spoke to the registered manager regarding staff rotas and the concerns about staff staying the duration of the visit. They informed us they had an electronic system to monitor this and were regularly seeking people's views on this. They informed us that occasionally staff were delayed. However, this would be due to unforeseeable circumstances such as medical emergencies from other visits. Another person told us they felt staffing rotas were not consistent and staff changed without notice and at times staff did not stay the duration of the visit. They also informed us that they would address concerns raised by staff who walk to work and felt the visits were arranged in close proximity to each other. Our findings showed this was not always the case.

We looked at how medicines were recorded and administered. Staff had ensured that people's medicines were managed safely. Risk assessments had been undertaken to ensure people received the right support with their medicines. We looked at medication administration records which showed medicines had been signed for. Checks had been undertaken to ensure medicines had been given as prescribed. Evidence we saw showed that lessons were learnt, and improvements were made when things went wrong. For example,

where people's expectations had not been fully met and where errors such as medicines issues had occurred, staff had received supervision and discussed ways to improve their practices.

There was a lone working policy which provided staff with guidance to promote health, safety and welfare of lone workers. Lone workers are staff members who work by themselves without close or direct supervision and in a separate location to the rest of their team or manager. Before the inspection we had received concerns from staff about their personal safety and some staff shared their concerns with us during the inspection. The registered manager informed us that they were aware of the concerns in some neighbourhoods and would be working with staff to review how they can enhance their personal safety. There was out of hours support for staff who worked after normal business hours such as evenings and weekends.

Policies and practices in the service ensured people were protected by the prevention and control of infection. For example, staff had received induction and training on infection control and prevention. Personal protective equipment such as gloves and aprons had been provided. Staff had received food hygiene training. This helped to ensure people would be protected from risks of infections.

Good

Is the service effective?

Our findings

We received mixed feedback from people and relatives about the knowledge, expertise, skills and caring approach from the staff. The majority of people felt staff had expertise and knowledge to deliver safe care. However, two people said they were concerned about the skills of some care staff in relation to moving and handling procedures. Comments from people included, "They do have the right skills, my [relative] needs people to lift him up in order to move him and he has a hoist, they definitely know what they are doing and are experienced." However, another person informed us they witnessed two care staff lifting a person incorrectly and felt the two staff members did not have confidence doing this. The registered manager informed us they had responded to concerns about moving and handling skills and have bought a hoist which staff used for training and to check their competences.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In people's own homes, and in the community, this is usually through MCA application procedures called the Court of Protection authorisation.

We checked to see if the provider was working within the principles of MCA. The staff who worked in this service made sure that people had choice and control over their lives and supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Care records showed staff sought people's consent before the service was provided. We saw staff had sought consent from people for example, to manage their medicines. However, we noted that the service had not recorded how they had assessed people's mental capacity before considering any best interest decisions. There were no mental capacity assessments completed where this was required. We spoke to the registered manager and the operations manager regarding this. They informed us that they had relied on assessments by other professionals such as social workers. The provider is required to undertake their own assessments of capacity. They informed us that going forward, they would ensure that each person will have a mental capacity assessment to demonstrate how they have reached the decision on people's ability to make specific decisions. This would ensure that the service is meeting its responsibilities and complying with the principles of the MCA.

We recommend the registered manager to seek guidance and follow best practice in the application of mental capacity principles.

There was a variety of learning and development pathways in the service. For example, there was face to face training, e-learning, spot checks and supervisions. Staff told us the training and support they received had given them the skills, knowledge and confidence they needed to carry out their duties and

responsibilities effectively. All staff members we spoke with told us they were supported to access any training related to the people they supported. Comments from staff included, "I have received the standard training and specific training related to the person I support." In addition, staff members had been provided with spot checks to check how they delivered care in the community and monitor their practice and time keeping. Since our last inspection a quality assurance officer had been employed who was responsible for monitoring staff in the community and reviewing care delivery.

Staff also told us that they received regular supervision. Staff added that they could approach the registered manager for support whenever they needed them. However, we noted that there were some shortfalls in staff supervision. Not all staff were up to date with their supervisions. The registered manager assured us that this would be rectified immediately.
Care files were clear in their guidance to support the staff to meet the individual nutritional needs of people. Staff had clearly identified people who required support with their nutritional needs. Nutritional risk assessments had been completed that identified what support people required. Where specialist nutritional support had been identified, for example where there was a risk of choking, care plans and risk assessments had been developed. Staff who supported people with meal preparation had received food and hygiene training.

We found the registered provider had a proactive approach to meeting people's needs especially where people had complex dietary needs. For example, we found they were supporting an individual who required alternative ways to support their nutritional intake. This included nutrition via a percutaneous endoscopic gastrostomy tube (PEG) to ensure the person would receive the right level nutritional support. Staff had been trained by specialist professionals to ensure they managed the PEG safely.

Records confirmed that people's health needs were frequently monitored and discussed with them. Some people had health action plans which showed they had their health needs reviewed regularly by health professionals. They demonstrated that people had received input from health professionals such as, dieticians and speech and language therapists.

Good

Is the service caring?

Our findings

People told us they were well supported and well cared for. Comments from people included, "They are extremely caring, when they come into my flat they always ask me how I am, I feel it's genuine how they come across" and, "They are very caring, they look after my [relative] very well and the other thing I like is that they always make sure they ask me too how I am, they are wonderful I've no complaints at all." Another person told us, "They are respectful as my [relative] always says now wipe your feet on the mat and they shout to him I have wiped my feet very well can I now come in, we have a laugh about this."

People we spoke with who were still using the service told us they trusted the staff and the service in general with their care. Two people who had stopped using the service gave contrasting views. We noted that the provider had responded to the concerns they had raised and continued to proactively seek people's views to improve their experiences.

People told us that staff had a sensitive and caring approach. There was a staff code of conduct which stressed the importance of respecting people's individuality and treating them as equals. Staff had received training which included guidance in equality and diversity. We discussed this with staff; they described the importance of promoting each individual's uniqueness. There was a policy on equality and diversity which was in line with Equality Act 2010. This law legally protects people from discrimination in the work place and in wider society.

Through our discussions with people and their relatives, we noted that arrangements had been made to meet their personal wants and diverse needs. From the information contained in their care records, we saw people were fully enabled to develop and maintain their independence where possible.

Staff explained how they promoted independence, by enabling people to do things for themselves. One staff member said, "We put extreme efforts in ensuring people can increase their independent living skills to do as much as they can. Care records outlined the goals and outcomes that people wanted to achieve and what support they needed.

There was evidence of how the provider had engaged with people during the design and delivery of care. People's records showed their daily routines which were person centred. Care files demonstrated a thorough approach that ensured people, or relevant relatives and professionals who acted on their behalf, were involved in and agreed to the care delivered. Information relating to how to access advocacy services was available. This ensured people were supported to make safe decisions. Advocacy in all its forms seeks to ensure that people, particularly those who are most vulnerable in society, can have their voice heard on issues that are important to them. It defends and safeguards their rights.

Good

Is the service responsive?

Our findings

Eight of the people and relatives we spoke with told us they received personalised care that was specific to meet their needs and they were involved in the planning, goal setting and reviewing of their care. Comments from people included, "They listen to what I want for my lunch and make it for me, that's important as it's my choice isn't it?" and, "The carers made contact with the district nurses as my skin was sore, they will do anything for you, even nipping to the shop."

People's care records demonstrated that the service had ensured that people's care plans fully reflected their physical, mental, emotional and social needs. They had been developed, where possible, with each person, family and professionals involved with them, identifying what support they required. Care records had been reviewed to ensure they continued to reflect people's needs.

Staff completed a range of assessments to check people's abilities and review their support levels. For instance, they checked individual's needs in relation to mobility, mental and physical health and medicines. Any specific requirements for each individual had been identified.

Staff members were recruited and deployed based on their ability to meet people's needs. The registered manager informed us they ensured staff were matched to the needs of people using the service. Some of the care staff we spoke with demonstrated that they had taken time to familiarise themselves with people's care records before care was delivered. However, two staff members told us this was not always possible, and they had visited at times without full details of the person's needs. We spoke to the registered manager who informed us that staff will always be given basic information about people's risks and needs before visiting unless it was an emergency cover. They called this a baseline assessment. The provision of information would ensure that staff have awareness of risks and needs of people before supporting them.

People were supported to maintain local connections and important relationships. Some people had been supported to regularly maintain contact with their local community and to continue accessing public facilities in the community. This included visiting their own GP and to undertake their own shopping with support from staff. One person said, "I have a care worker [name removed], he spends 2hours a week on a Thursday he takes me out shopping for one hour and then the other hour is spent with me helping me to clean the house, it's a really good service, I don't need anything else." This helped to reduce social exclusion for these individuals.

Technology was used to support people to receive care and support, this included, use of electronic call monitoring systems to monitor care visits and share care records with staff securely on their mobile devices, broadband, telephone facilities and Wi-Fi connectivity for their office staff.

The service had a complaints procedure which was made available to people and their representatives when they started to use the service. The complaints procedures could be adopted into different formats where required to enable people who used the service to understand the procedures. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to

appropriately. Contact details for external organisations including social services and CQC had been provided should people wish to refer their concerns to those organisations. One person told us, "If I needed to complain or make a comment about the service, I have all the numbers and this was explained to me clearly who I need to speak with."

We reviewed complaints that had been dealt with in the service and found investigations had been undertaken and in some cases, management had visited the people to discuss their concerns and find a solution. We would expect the provider to ensure outcomes of complaints are formally shared with people and people are provided with information on how to appeal if they are not satisfied with the outcome. The registered manager informed us they will put that into action.

We saw a number of compliments received from relatives and from professionals. Examples included, "Some workers go above and beyond their duties. They have been incredible whilst there is the odd few who may have problems. The girls who do an amazing job."

We checked whether the provider was following the Accessible Information Standard (AIS). The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. There were arrangements to produce records in various formats to meet people's needs. People's records had communication care plans that detailed people's communication needs. We would expect the provider to establish a policy on the Accessible Information Standard to ensure consistency in their practices.

Records we reviewed demonstrated that staff had received training in relation to supporting people towards the end of their life. This would ensure that people will be supported to ensure a pain free and dignified death.

Good

Is the service well-led?

Our findings

We received mixed comments regarding management from people who used the service and staff. However, majority of the feedback was positive and complementary to the management team at Heron Care Limited. Comments included, "There are two managers I speak with, one of them came out to see me as I couldn't get along with one of the carers. The area manager listened to my concerns and removed the carer from visiting myself, I was very pleased and felt a lot more comfortable with this. They do respond and listen to what I have to say." And, "The care managers explained exactly what I needed to do right at the start, they made everything very clear, I know exactly who I need to speak to if I did have a complaint however I haven't had, and I don't think I will have as they are excellent." However, two people told us they did not feel their concerns were dealt with robustly by the management team.

Comments from staff included, "The management team is supportive and will listen to concerns", "Communication between office and staff on duty could be better. Also, more staff appraisals and supervision are needed." We discussed the comments with the registered manager who informed us that they have employed two new care managers and a quality assurance officer who will be focusing on ensuring the concerns raised by people and staff are rectified. We saw evidence of actions that had already been undertaken which showed they had responded and acted on concerns.

Professionals shared positive comments about the management of the service. They informed us that any concerns or shortfalls that they identified on their quality visits were acted on promptly. They commented that the service had been quick to confirm the actions they are taking to address any identified shortfalls in service. The professional found them to be 'extremely pro-active, co-operative and willing to work in partnership' to improve the service where required.

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.

During our inspection our checks confirmed that the provider was meeting the requirement to display their most recent CQC rating within their offices. However, they had not displayed their ratings on their website. We discussed this with the registered manager who assured us that this would be resolved immediately and that it was an oversight due to their website hosting company ceasing to operate. We asked them to resolve this soon after our inspection.

The registered manager had notified CQC of accidents, serious incidents and safeguarding allegations as they are required to do. This meant we were able to see if appropriate action had been taken to ensure people were kept safe.

Staff we talked with demonstrated they had a good understanding of their roles and responsibilities. There were clear lines of responsibility and accountability with a structured management team in place. The

registered manager was experienced with an extensive health and social care background supported by a team of care managers and the operations manager.

All staff had delegated roles including provisions of personal care, training, managing and supervising care staff monitoring staff visits and providing oversight on the delivery of care. Each person took responsibility for their role and had been provided with oversight by the registered manager.

Staff meetings were held on a regular basis. In addition, quality checks were carried out regularly. Improvements had been made to include six monthly surveys seeking feedback on people's safety. The registered manager analysed any comments and had acted upon them. The feedback we saw from the surveys demonstrated people felt the service was of a good quality.

We saw initiatives by the registered manager which demonstrated how they cared for their workforce. For example, they told us that they had introduced a cycling to work scheme, a counselling service was available for staff should they require it. They also told us, a shared company car was available for staff to use if needed and transport was provided for staff if required during bank holidays with fuel cards to help staff with fuel costs. These measures were aimed at improving the health and wellbeing of the workforce.

The registered manager had auditing systems to assess quality assurance and the maintenance of people's wellbeing. We found regular audits and quality checks had been completed. These included medicines and care records. They had adopted quality self-assessments or audits of the service which were based on CQC inspection methods of assessment and identified any areas that needed improvements. Any issues found on audits were quickly acted upon and lessons learnt to improve the care the service provided.

We saw evidence to demonstrate that the service worked well with other local organisations to share and keep up with best practice. This included adopting initiatives such as, 'Pass and Go' information sharing initiative in collaboration with the local council. This allowed the staff and the service to securely share people's care records and for staff to have live care plans on their mobile devices. There were strong links with the local community and the service had continued to strengthen their relationships with keys organisations from their local area. We also found there were arrangements to ensure the staff were kept up to date with good practice and changes in regulations through attendance at local provider forums and workshops.

While safeguarding concerns and complaints had been raised against the service since our last inspection, we noted that the registered manager and the staff had responded appropriately to the issues to ensure safety concerns were addressed and that people's experiences improved. During this inspection we found the registered manager and staff had worked hard to sustain the standards that they had set at our last inspection. Some areas that required improvement were noted, including views shared by staff and people. This was shared with the registered manager and the operations manager. They acknowledged and had plans in place to make the required improvements and address concerns from staff. It was evident the service had sustained their rating of 'good'. We saw there were visions, plans and a desire from the registered provider, the registered manager and the staff to continue to move the service forward and ensure people received the highest standard of care.

The registered manager and the staff were transparent with the inspection process and responded to all our requests for information.