Z & C Care Ltd

Home Instead Senior Care Huntingdon

Inspection report

1 Ramsay Court
Hinchingbrooke Business Park
Huntingdon
Cambridgeshire
PE29 6FY

Tel: 01480454293

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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

Home Instead Senior Care (Huntingdon) is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It is registered to provide a service to older people, people living with dementia and people with mental health needs. Not everyone using Home Instead Senior Care (Huntingdon) received a regulated activity; the 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.

This announced inspection was carried out between 18 and 21 June 2018. At our previous inspection on 5 and 6 April 2017 we asked the provider to take action to make improvements to ensure staff knew how to safeguard people from harm and that notifiable incidents were reported to the Commission. The provider submitted an action plan and said they would make the necessary improvements by date 15 June 2017. At this inspection, the necessary improvements had been made and the service was rated Good. At the time of our inspection there were 29 people using the service.

The service did not have a registered manager. A new manager was in post. Following our inspection their application to be registered was agreed by the Commission. A registered manager is a person who has registered with the CQC 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 received a safe service. Staff understood their responsibilities in relation to safeguarding. They had received training and were able to recognise any safeguarding concerns. There were safeguarding procedures in place to guide staff on steps to take if they had a concern. The manager used information from accidents and incidents helped them learn lessons to prevent any potential recurrence. The staff recruitment process helped ensure that the necessary checks were completed before new staff commenced their employment. Sufficient staff who had been given the necessary training were in post and they were deployed to keep people safe.

Where risks to people were identified, for example falls, there were risk management strategies in place to guide staff on how to minimise those risks.

Staff were provided with the training and assessed as competent to provide people with support to take their medicines as prescribed. Effective action had been taken to ensure staff administered medicines as defined in the provider's policies.

People received a service that met their needs. Following an initial assessment people were allocated staff members who had the right skills to meet their specific needs and promote their independence. People were enabled to access health care services and as a result this maintained their health and wellbeing. People were supported to have sufficient quantities of food and drinks of their preference.

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 received a caring service. Staff had developed caring relationships with people. Staff enabled people to express their views including with support from advocacy services. Advocates are independent of the service and they can support people to raise and communicate their wishes. Staff respected people's privacy and dignity. Staff had been given time for their training and this helped people to be cared for with compassion. Staff supported people in an equal way no matter what each person's needs and independent living abilities were.

People received a responsive service. People, and or their relatives, were consulted about how their care was to be provided. Concerns raised by people were used to drive improvement and theirs and their relatives' compliments were used to recognise what worked well. Staff used their skills to communicate with people effectively and requests for assistive technology were used to help people's care was as personal as practicable. People could be assured that, when required, they would be able to have a dignified and pain free death.

People received a well-led service. People contributed, and had a say, in how the service was run. The nominated individual and manager motivated their staff team in various ways including shadowing experienced staff, team meetings and supervisions and mentoring. An open and honest staff and team culture had been enabled by the manager. This encouraged staff to communicate and share good practise as well as reporting any poor care should this ever occur. Quality assurance, audit and governance systems were effective in identifying and implementing areas for improvement when these were needed. The provider had notified us about important events that they had to.

Further information is in the detailed findings below.

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 were supported to stay safe by staff who were knowledgeable about safeguarding procedures.

Risks to people were identified and managed well. This included those for the administration of medicines.

People were safely supported by sufficient staff who had been recruited safely.

Is the service effective?

Good

The service was effective.

People's assessed needs were met by staff who had undertaken relevant training.

People were supported to eat and drink well.

People were enabled to access health care services by staff who had a good knowledge of people's needs.

People's independence was promoted by staff who helped them to make informed decisions.

Is the service caring?

Good

The service was caring.

People were communicated with by staff in a respectful way and staff showed concern or their wellbeing.

Systems were in place to support any person who had a need for advocacy.

People's privacy and dignity was upheld and promoted by staff.

Is the service responsive?

Good

The service was responsive.

People had a say in how their care was provided.

People's concerns were acted upon before they became a complaint. Compliments were used to recognise what worked well.

Systems were in place to help ensure people could have a dignified and pain free death.

Is the service well-led?

Good

The service was well-led.

The nominated individual and manager supported staff to work in an open and honest way. This helped promote equality as well as building good working relationships.

Quality assurance, audit and governance systems were effective in driving improvements.

Staff with a management role had a good working relationship with other stakeholders. This helped contribute to the overall quality of people's care.

Home Instead Senior Care Huntingdon

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 between the 18 and 21 June 2018 and was announced. The inspection was undertaken by one inspector. We gave the provider 48 hours' notice as the service is small and we needed to be sure they were in. This was also because some of the people using the service could not consent to a home visit or phone call from an inspector, which meant that we had to make alternative arrangements.

Before the inspection the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least annually. This provides us with information about the service, what the service does well and improvements they plan to make. We used this information to assist us with the planning of this inspection. We also looked at other information we held about the service. This included information from notifications the provider sent to us. A notification is information about important events which the provider is required to send to us by law such as incidents or allegations of harm.

Prior to our inspection we contacted the local safeguarding organisations to ask them about their views of the service. Their views helped us to plan our inspection.

On the 18 June 2018 we spoke with six people who used the service and three relatives of people who were not able to speak with us. On 19 June 2018 we visited the provider's office and we spoke with the nominated individual. We also spoke with the manager, two office based staff with management roles and a care staff member. On 21 June 2018 we spoke with four care staff by telephone.

We looked at care documentation for four people using the service and two people's medicines'

administration records. We also looked at two staff files, staff training and supervision planning records and other records relating to the management of the service. These included records associated with audit and quality assurance, accidents and incidents, compliments and complaints.

Good

Is the service safe?

Our findings

At our previous inspection on 5 and 6 April 2017 we found that improvements were needed in the ways people were supported to be safe. Where incidents of harm and potential harm had occurred, the registered manager at that time had not taken steps to ensure that people were safeguarded from further harm.

This was a breach of Regulation 13 (1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question of, is the service safe to at least good. At our inspection between 18 and 21 June 2018 we found that the provider had followed their improvement plan and the necessary improvements had been made. These improvements included the reporting of safeguarding incidents, liaising with the local safeguarding authority and acting promptly on their advice. As a result of these actions, incidents of harm, or potential harm had been reduced and there was more open reporting by staff.

People told us they were safe. One person said, "I have [staff] every weekday and they always arrive on time, stay with me for an hour and they make sure I am wearing my call bell lifeline pendant." Staff told us about the different types of potential harm as well as the signs and symptoms of these. One staff said, "I would know if someone was self-neglecting by their lack of appetite, not being clean or not taking their medicines when I prompt them. I would report this to the manager."

Staff were given information and the details they needed for reporting any concerns about people's safety including the local safeguarding authority. Staff had been trained in, and updated about protecting people from harm, and they were able to tell us what situations needed to be reported and that people would always be safeguarded. Where incidents occurred, lessons were learned. For example, by changing the strategies to support people with behaviours which could challenge. Where information about risks to people needed to be shared such as, with a social worker, then this is what happened.

Risk assessments were in place and these had identified how risks to people were managed. For example, for people with a risk of choking or behaviours which could challenge others. Staff told us that they had been trained to hoist or assist people to mobilise using equipment which they checked before use. Risks associated with these tasks had been minimised. One staff member told us, "[Name] has a risk assessment for walking their dog. We don't leave the dog lead lying around. This makes it safe as I follow the guidance." In addition, risks associated with the environment where staff worked in people's homes had been assessed and actions had been taken to minimise these risks such as for trip hazards.

Records about people's care were up-to-date and these were available to staff to support people to stay safe. One relative told us, "[Family member] isn't safe to go out on their own so staff go for a walk with them. I feel reassured that [family member] is in safe hands."

Appropriate recruitment checks remained in place to ensure that suitable staff were employed. Information

received prior to new staff starting their employment included a criminal record check (Disclosure and Barring Service), evidence of qualifications, identity and employment references.

Staffing levels continued to be monitored by the nominated individual and the manager. This was to ensure sufficient staff were available to provide the care people needed. The nominated individual told us that although they had many potential applicants, only those staff who met their standards were considered for employment. One person told us, "I never worry about [staff]. They don't rush me and if they are ever running late someone from the office always lets me know." Where regular staff were on leave or off sick, other staff had the capacity to cover these absences.

People's medicines were stored appropriately in people's homes and administered by trained staff. Not all staff had adhered to the provider's policy to record people's medicines on the medicines administration chart in May 2018. It was therefore not clear if people had been administered all their prescribed medicines. The nominated individual told us that their operations' manager was aware of this and that a new form would be implemented. This was as well as retraining staff and implementing an electronic audit process that would more accurately identify errors or omissions.

People had regular medicine reviews undertaken by their GP. This ensured medicines they were taking were still appropriate for their needs. A relative told us, "From the records staff make in [family member's house, I can see that they always get their [medicines] as prescribed."

Staff had been trained on infection prevention and control procedures. As a result of this we found that any risk to people's hygiene and cleanliness was managed well. Staff adhered to the provider's policies about this. One relative told us, "[Staff] always wear their gloves and aprons. I have never seen them not wash their hands. A staff member said, "We have plenty of supplies of protective clothing (PPE). I can always pop into the office to collect more. We do get checked upon to make sure we are wearing our PPE."

Good

Is the service effective?

Our findings

All of the people and relatives we spoke had a shared and positive view of staff's knowledge of their health, social and care needs. Staff had been provided with training which helped give them the skills they needed to meet any person's needs no matter what these were. The provider's representatives consulted with people and/or their relatives which looked at the whole person, considering all their care needs and how their care and support was provided. This meant that staff skills were matched to the person's needs. One person told us, "[Staff] seem to know what they are doing. I don't have to tell them as they know me so well. New [staff] are introduced to me so I am never faced with a stranger." Another person told us, "I was really happy with how [staff] came to see me and assess what I wanted. I felt listened to as I can now absolutely say that they meet my needs. We have developed a good rapport. They make sure I use my walking sticks."

Staff used their knowledge about the equipment people used to enhance their care. For instance, assistive technology was used to alert staff to people's safety outside of planned care calls. For example, if a person left their home, staff knew when this was and who to then contact to help ensure people were kept as safe as practicable.

Staff had the skills, knowledge and experience to deliver effective care. A planned programme of training for staff was in place. As well as mandatory subject areas relevant to their role staff also received training in subject areas specific to people's healthcare needs such as diabetes and Parkinson's Disease. This enabled them to understand and have the right skills to meet people's individual needs more effectively.

Various systems were in place to provide the necessary support to staff based upon their role. This included an induction period where new staff shadowed experienced staff and formal supervision where staff were given an opportunity to feedback what worked well and any additional support they may need. One staff member told us, "There are set subjects to cover such as any planned training or refreshers for this, as well as how I feel and anything I need. If you need any support from the manager, you get it."

People were supported to eat and drink sufficient quantities of a healthy balanced diet. This was by staff who had knowledge about nutrition. One relative told us, "[Family member] eats well. Not for me, but [staff] have the knack."

People, when required, were supported to access healthcare professionals. For example, people were given guidance from a speech and language therapist, GP or community nurse. This was to help ensure people who were at risk, ate and drank well including supplements such as full fat cream. One staff member said, "Sometimes taking a person into the kitchen helps them to choose from the fridge as they can see what's available. It's a technique that works."

Staff provided support for people to attend healthcare appointments. One relative, told us, "[Family member] has had a few falls. Nothing serious but [office staff] have alerted the local authority falls team. The GP has checked medication but otherwise [family member] remains independent."

The 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 authorisation procedures for this in services provided in the community are applied for and authorised by the Court of Protection (CoP). We checked whether the service was working within the principles of the MCA and found this to be the case.

We found that staff understood the decisions people could or couldn't make as well as how to respect people's choices. One person told us, "I am always offered a choice. I chose what to eat and if I want to go out. [Staff] come with me but only to keep me safe. I like the company." Arrangements were in place for where decisions had been made in people's best interests. For instance, such as relatives with a power of attorney to make decisions about people's health and welfare.

Restrictions on people's liberty were also being considered in response to people who did not have the mental capacity to understand the risks associated with going out of their home on their own. The use of assistive technology was being considered to make sure this was in the person's best interests and that there was no lesser restriction. The provider was liaising with the person's social worker to help keep the person safe.

Good

Is the service caring?

Our findings

People were looked after and cared for by staff who knew them well enough to make sure each person knew they mattered. One common theme throughout our inspection was how complimentary people were about how staff cared for them with compassion. One person told us, "[Staff] are like a family member to me. We share a laugh. They are punctual, and I definitely feel listened to." Another person said, "I have developed such a bond with [staff]. We can have a laugh. I know they know my preferences as I have never had to tell them what to do. They know how I like my tea, in a china cup and how much milk, exactly!" A third person told us, "I heat my towels before staff arrive on time and they wrap me in these after my shower. What could be more caring? I look forward to their visits as they look after me like royalty."

Staff used alternative ways to communicate with people such as any person with a hearing or visual impairment. For example, by reading to people and speaking slightly louder and more slowly. This showed us that people came first and foremost and that staff were considerate of each person's needs. One compliment a person had sent to the provider read, "May I take this opportunity to say, a very big thank you to [the manager] and your amazing staff team, who have looked after [family member] with the care and dignity they deserve. This past year you have surpassed your remit for caring for [family member] as if they were your own [family member]."

Staff had their care call roster two weeks in advance. This allowed them to plan any training to prevent any clashes with people's care calls. One person said, "[Staff] spend time with me. It is so lovely to sit, have a cup of tea with them and chat about the good old days. I never, ever feel as if I am being rushed."

People were supported, where required, to access advocacy services. These services provided independent support and advice, and where necessary advocate for them, about their care and treatment. The manager told us that if required, people or their representative if the person did not have the ability to do this for themselves, could be sign posted to national organisations for advice and support about advocacy.

People's privacy and dignity was respected. People and relatives we spoke with were complimentary about how respectful staff were. This was in addition to how much staff valued people's privacy. One person told us, "[Staff] wash the bits I can't reach. I do it at my pace and in the privacy of my bathroom." Another said, "I live at home but [staff] enable me to do this by doing those bits I can't, like helping me get out of bed." One relative told us, "When I have been with [family member] staff speak in a respectful manner. [Family member] lives with dementia and staff prompt them rather than telling them what to do. [Staff] are very understanding." One staff member said, "I get everything ready beforehand such as warming up the shower and getting towels and other washing items ready. I keep the person's modesty covered as much as possible, as well as giving them their own time. I wait outside the bedroom until they tell me they are ready."

Good

Is the service responsive?

Our findings

People, and / or, their relatives acting on their behalf, were supported to contribute to the development of their care plans. This helped the person to receive care that was personalised and responsive to their needs. One person told us, "The supervisor [staff] came out when I started with [the provider]. [Staff] can absolutely meet my needs. They have tailored my care to meet my needs. They prepare my chosen meals and I cook them. It works well."

One staff member told us how had supported a person who was living with dementia. They had taken them out to their farm to pick out weeds, watch the animals, talk about the crops and reminisce about their past life. The staff member told us, "I use positive conversations if ever they are a bit down. This soon cheers them up and it's as if they were back farming once again. It's so nice to see them being positive." This way of supporting people made a real difference to their lives. Other examples included doing a person's hair in their chosen style, playing board games, reading the person's favourite books and in some situations having a cup of tea was the person's preferred way to spend time with staff chatting and reminiscing about many of their life's happy memories. Staff used these conversations to stimulate further discussion. This helped people to feel at the heart of their care.

The provider ensured that peoples care met their needs. This was by taking into consideration their age, disability, race or religion and making any reasonable adjustments including giving people the time they needed for all their care needs. This included anything that staff needed to be aware of such as ensuring people wore their prescribed glasses or hearing aids. Care plans included, the person's life history and knowledge gained by staff such as the time people liked to eat, sleep or go out for a walk. One staff member said, "By having at least an hour to provide people's care, we can do things which would otherwise not be possible. For example, reading a book for people and creating homemade meals that people loved."

Staff used their mobile phones as a means of ensuring they logged their care calls to people's homes. One office staff member said, "I can monitor [staff's] arrival and departure times. If we need to send alternative staff we can do this." People also used technology such as their mobile or home phones to summon emergency assistance if needed. This was in addition to an alarm call pendant they wore. This was provided under a separate service that people could use to summon emergency care assistance. One person told us that staff were very helpful and always reminded them to wear their pendant to summon help in an emergency. They said it was their life saver when they recently fell as an ambulance came quickly.

The service had not received any formal complaints through their complaints process in the last twelve months. Records showed that concerns were acted upon before they became a complaint and the provider's proactive approach had addressed any concerns preventing them from escalating into a complaint. For example, the service proactively engaged with Commissioners or healthcare professionals as soon as they identified people's needs were changing.

Compliments were used to identify what worked well, such as in the way service responded to people's changing needs. One such compliment showed how, as a result of staff's interventions, the person's

anxieties had greatly reduced. This was by speaking with the person whenever they rang. loved one's life in the hands of the provider. Another compliment stated how happy a relative was due to the trust their loved one had in care staff in meeting the person's needs.

At the time of our inspection no one using the service was being supported with end of life care. Records showed us how the service had planned for and delivered end of life care and worked in partnership with other healthcare professionals. We saw from these records how the manager had arranged the support of Macmillan and other palliative care organisations to provide people with healthcare support. One compliment from a person's relative read, "I can't' thank you enough for the superb care you gave not only [family member], but also to me." Another compliment had identified how end of life care was a vocation and that the care staff had all done "A truly wonderful job".

Staff were provided with the information they needed about people's advanced decisions about their end of life care. This included information from health professionals and the provider's policies which were used to guide staff as to how they could determine people's end of life wishes. The manager told us how they had in the past liaised with palliative care nurses, GPs and other community care professionals. This was to put in place anticipatory medications and as a result people could have a dignified and pain free death.

Good

Is the service well-led?

Our findings

At our previous inspection on 5 and 6 April 2017 we found improvements were needed. The registered manager and provider had not always notified the Care Quality Commission (CQC) about incidents, that by law, they are required to do so. This was a breach of The Care Quality Commission (Registration) Regulations 2009 regulation 18.

Since the last inspection the provider, where required, had reported any notifiable incidents to us and the local authority safeguarding team.

The service did not have a registered manager in post. Following our inspection their application to be registered was agreed by the Commission. A registered manager is a person who has registered with the CQC 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.

The service had a clear and effective governance framework. Various systems were used to monitor the quality and safety of the service We saw that as a result of this governance that the provider was prominently displaying their previous inspection rating in the office and on their web site. This showed us they were aware of their responsibilities.

Spot checks were carried out to monitor the quality of care being delivered and to ensure staff demonstrated the values and behaviours expected of them.

Staff were supported in a proactive and positive manner. One staff member told us, "I absolutely do get the support I need. If there is anything at all I am not sure about I call the office [staff] or the out of hours number. I always get a response that helps me." Other staff said that they also had this level of support and that they worked as a team. One said, "I have full confidence in the office [staff]. People come first. I wouldn't hesitate to report any poor care. I feel 100% confident that I would be supported."

Various quality assurance, audit and governance systems were in place and the majority of these were effective. Examples of this included, care plan audits, calls to people to make sure they were satisfied with all aspects of their care as well as where change needed to be implemented. For instance, additional staff with new skills or training on any person's new equipment. The nominated individual was in the process of improving the medicines' administration audits to more quickly identify any errors. This would allow prompt and effective action to be taken as soon as practicable rather than after a few months.

Staff who had a management role kept their skills up-to-date with support from representatives of the provider. This was as well as these staff having access to more experienced staff's knowledge and support. One person told us, "[Staff] all have the same standards of care so they must be supported well. I can ask for anything and someone [from the office] gets back to me quickly and efficiently. I can't fault any of them." We found that staff embodied the values of the service by working to the standard that was expected of them.

Appropriate arrangements were in place to assist staff with their development. This was achieved by various means including, formal supervision, annual appraisals and regular team meetings. Because of this, the manager supported staff to work together to provide a service that met people's expectations.

Care staff were reminded of their responsibilities at various times such as when they visited the office, during shadowing experienced staff as well as during training updates. Staff were held accountable for their decisions and improvements were implemented or planned when things did not go as well as expected.

People had a say in how the service was run including regular face to face meetings with care and management staff, monitoring of their care by telephone as well as quality assurance survey questionnaires. People's, relatives' and staff's views gained from this quality assurance survey were analysed to identify what worked well. The provider used information from this survey to help identify where improvements could possibly be made such as with introducing new technology. This was planned to more quickly identify if staff correctly recorded people's medicines. One person told us, "I just need to pick up the phone, tell [office] staff what I need and it is acted upon. It could be as simple as cancelling care when I am away or extra help if I need it." One of several positive comments in the survey read, "[The service] is all working well. Nothing could be improved for me."

A common theme we identified was how happy people were with the overall quality of service they received. One compliment stated, "I would like to say how much we have appreciated the quality of care that Home Instead provided for [family member]. Your [staff] we always kind, caring and well trained." And, "I cannot thank you and your team for the superb care and support you have given not only [family member] but also to me." One person told us, "The quality of care can't be faulted. It is just everything that is good for me. The staff are always very good."

Lessons were learned from accidents and incidents such as changing the way people were supported following a fall or changing strategies for people with challenging behaviours. These changes helped drive improvement in the overall quality of people's care. For example, by liaison with the local authority falls team as well as a social worker to create strategies which helped ensure people's care was a good as it could be. One staff member told us, "As a result of [incident] the person's care plan now has details of how to make sure it doesn't happen again."

Management staff worked in close liaison with various external stakeholders such as community nurses, GPs, speech and occupational therapists and the local safeguarding authority. This working relationship ensured people received joined up care as well as ensuring the right support and/or equipment was in place before the person was discharged home.