Springfield Home Care Services Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Our inspection took place on 06 and 07 September 2016 and was announced. At our last inspection in October 2013 we found the provider was meeting the standards we looked at.

Springfield Home Care Ltd is a domiciliary care agency which provides personal care to people in their own homes. At the time of our inspection there were 517 people using the service. There was a registered manager in post; however, they were on annual leave when we visited. 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.

Although there was some activity designed to measure, monitor and improve the quality of the service we found this was not robust and the policy in place to define quality assurance activities was generic and incomplete.

Without exception people told us they felt the personal care provided was safe. The provider had ensured staff were trained in safeguarding and staff we spoke with understood the principles of this and their duty to report any concerns.

We found risk assessments in care plans were often generic and did not provide clear guidance for staff to ensure they worked in ways which minimised that risk. We saw the provider had identified this issue and was already working to make improvements in this area. We looked at some care plans which contained the new risk assessments and found they contained more detail.

Staff were recruited safely and we concluded the provider had sufficient staff to meet people's needs. Staff told us they were not always given sufficient time to travel between calls, although people we spoke said care staff being late was an issue of concern for them. The provider was investing in new software to help plan calls, which would improve things in this area.

We looked at records of medicines and found it was clear who administered their own medicines and how this had been risk assessed. Some care plans lacked guidance relating to medicines given as and when needed, also known as PRN medicines. The operations manager told us this would be addressed.

The provider had a rolling programme of training and refresher training in place. We saw new staff completed a thorough induction programme lasting 12 weeks, after which they had a formal appraisal to discuss their progress. All staff had an annual appraisal, however, we found there had been a misunderstanding between the management team and provider about what constituted formal supervision. Although staff had monthly face to face contact with supervisory staff, this was not as described in the provider's policy. The operations manager began working to rectify this during our inspection.

The provider had systems in place to request social workers undertake capacity assessments with people who may not have been able to make decisions about their care. Staff understood how to escalate any concerns about people who used the service whose capacity may have deteriorated.

People who used the service were very complimentary about the staff and their approach to providing care. Staff spoke about people they supported with fondness and respect. The provider had embedded principles of equality, diversity and human rights into their training..

The provider undertook an assessment of people's needs to ensure these could be met. We found care plans were regularly reviewed, although this process did not always evidence people's involvement. Some information such as desired outcomes for people's care and support were generic rather than specific to the person.

There were robust processes in place for the management of concerns and complaints. We also saw complimentary feedback had been recorded as part of the latest survey completed by people who used the service.

Staff and people who used the service gave positive feedback about leadership in the service. People and staff said they valued the fact senior staff had also been care workers. Staff told us they felt able to give feedback and make suggestions about the service which the registered manager listened to. There were regular staff meetings at which this could happen.

We found one breach of the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risk assessments in care plans were often generic and did not always contain guidance to help staff minimise risk. The provider had started to make improvements to this documentation.

Recruitment of staff was safe, and there were sufficient people employed to ensure the provider could meet their commitments to provide personal care. Staff told us poor scheduling meant they often did not have enough time to travel between calls.

Medicines records were up to date and completed correctly. We found some care plans did not contain instructions for giving 'as and when' medicines, and the provider told us they would address this.

Is the service effective?

Requires Improvement

The service was inconsistently effective.

There was a rolling programme of training in place to ensure staff skills and knowledge were kept up to date. New staff received a thorough induction.

The provider had a process in place to refer people to social workers for capacity assessments where concerns about people's capacity to make decisions were raised. Evidence of referrals was not always in people's care plans.

Staff had regular monthly contact with care co-ordinators who attended calls with them to monitor their practice. All staff had an appraisal at the end of their induction period and then annually after that. The operations manager told us they would ensure staff also had formal supervision meetings more regularly.

Is the service caring?

Good

The service was caring.

All people who used the service gave positive feedback about the

caring nature of the staff.

Equality, diversity and human rights were referred to in all training, and care plans contained guidance to prompt staff to help people maintain their independence.

Staff told us about ways in which they ensured people's privacy and dignity were respected, and we saw their approach to this was observed during spot checks.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provider carried out a pre-assessment to ensure they could meet the needs of people before they started to use the service; however, care plans were not always written in a person-centred.

The provider sought regular feedback from people who used the service about staff performance and whether their needs were being met. Staff told us they reported changes in people's needs to the care co-ordinators who ensured appropriate changes were made in the support and care provided.

There was a thorough process in place for the management of complaints

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's audit policy was generic and incomplete. Audit activity was not sufficiently robust to measure, monitor and improve quality in the service.

People who used the service and staff gave good feedback about leadership. Staff and people who used the service valued the fact senior staff had also spent time as care workers.

Staff said they were able to give feedback and make suggestions about the service which the registered manager listened to.

Springfield Home Care Services 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.

The inspection took place on 06 and 07 September 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of three adult social care inspectors 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 care service, and had experience of supporting older people who used health and social care services.

Before the inspection we reviewed all the information we had about the service, including past inspection reports and notifications of incidents sent by the provider. We also contacted the local authorities who commissioned services from the provider and Healthwatch, to ask if they had any feedback they wished to share with us. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We did not receive any information of concern.

We sent the provider a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information they sent us as part of our preparation for the inspection.

During the inspection we spoke with the provider's operations manager, a team leader, one care co-ordinator, the provider's training and development consultant and 12 members of staff. In addition we

spoke by phone with 19 people who used the service and 11 relatives. We looked at 18 people's care plans including records relating to their medicines. We also looked at other documents relating to the running of the service including staff, recruitment and training records, policies and procedures, surveys, quality assurance activities and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

In the PIR the provider told us, 'All staff including branch staff and management teams, have attended safeguarding training and are aware of how to raise alerts, courses attended include alertor, responder, it's everyone's job, and investigation training including how to complete the necessary notifications. All staff are aware of the whistle blowing policy, this was delivered within our induction and refresher training programme, and is also contained within the employee handbook and our company policies and procedures. We operate a robust recruitment process, whereby all new recruits go through a formal competency based interview process, with additional communication and literacy checks, full enhanced DBS check and a minimum of two professional references.'

All people we spoke with gave good feedback about the service and told us they felt safe having the provider's staff in their homes. One person told us, "I am safe because of good consistency of carers and the thorough knowledge of what has to be done." Another person said, "Very pleased with efficient carers who do their job safely and carefully, never forgetting what has to be done and we can talk about anything."

Staff we spoke said they had received training related to the safeguarding of vulnerable people, and we saw records confirmed this. Staff were able to describe the types of abuse people may be at risk of and could tell us about how they would identify and report any concerns. There was consistent confidence the registered manager, team leaders and care co-ordinators would act appropriately on any concerns raised. The provider's whistleblowing policy was included in the staff handbook, and staff told us they knew the importance of reporting concerns about any poor practice and had been told about these processes.

Care plans we looked at contained risk assessments, however, these were mainly generic and related to environmental issues relating to people's homes rather than risks associated with providing personal care. For example, identifying risks specific to individual people during hoisting, and providing guidance for staff to refer to in order to understand how to minimise that risk. We found there was a guide for staff to explain how they needed to assist people on each call and staff we spoke with told us about how they used their training to understand and reduce risk whilst providing personal care. We discussed this with the operations manager and team leader, and they showed us a newer risk assessment which they had introduced and begun to include in people's care plans. Where this had been completed we saw more detailed information about risks specific to individual people's needs and the staff guidance in place to minimise this risk.

People we spoke with did not raise any concerns about the staff's approach and knowledge when providing care. One person said, "It takes two people to hoist me into my wheelchair so that I can go into my office. I am ready to go safely."

We looked at the recruitment records of 11 staff. These contained application forms and written interview notes which showed how the provider had established the applicant's suitability for the role. In addition we saw the provider carried out background checks including identity checks, asking for employment references, recording reasons for any gaps in employment and asking for information from the Disclosure and Barring Service (DBS). The DBS is a national agency which holds information about people who may be

barred from working with vulnerable people. These checks helped employers make safer recruiting decisions.

There were sufficient staff available to provide care, and the operations manager told us they had additional staff who could provide cover for absences and holidays. We saw the provider monitored call attendance times, and one local authority confirmed the provider's performance met the standard required in their contract. One person who used the service told us, "If they are going to be late they do try and let me know. I can't fault them on time keeping. A person from the office comes once a month to look at the timesheets." Another person said, "If the carers are going to be late they always let me know, so I don't worry." The team leader told us they used a piece of software to produce the visit rotas, and this allowed for a standard six minute travel time between visits. Staff we spoke with told us there was not enough time scheduled for them to get from one visit to the next, and several staff told us the gap between visits was often three minutes. We raised this with the operations manager who told us they had identified this issue. They said the provider had invested in new scheduling software that would take account of distance and improve their performance in this area.

On the first day of our inspection, staff we spoke with told us they were receiving refresher training in the safe administration of medicines, and we saw records which confirmed this was up to date. People we spoke with did not raise any concerns about assistance they received in this area, and we saw documentation in care plans showed some people managed their own medicines.

Not all care plans we looked at contained guidance on when staff should administer 'as and when required' (PRN) medicines. This meant staff may not have been able to recognise instances where it would be appropriate to offer these medicines. We spoke with the operations manager who acknowledged this information was not documented and told us they would take action. After the inspection we received confirmation that written PRN protocols had been discussed with the supervisory team and would be introduced into care plans as part of the review processes.

A relative of a person who used the service told us, "They watch [name of person] closely when she takes her medicines as sometimes she spits them" We reviewed the medicines administration records (MARs) of 18 people. We saw a record of people's medical history and also found care plans contained detailed medication risk assessments which clearly identified whether people self-administered their medicines or the level of support they needed. MAR charts we looked at were complete and up to date.

Requires Improvement

Is the service effective?

Our findings

In the PIR the provider told us, 'New employees are taken through an induction, mandatory training, prepare to work workbooks and working to the Care Certificate. After the induction training the new employee with shadow with an experienced member of the team getting to know the service, the customers, the area before observations, then allowed to work alone. This forms part of our 12 week on boarding journey and links in to the probationary review to confirm individuals employment with the business and also look at ongoing career development and training opportunities reviewed at one-to-one supervisions/appraisals.'

Records we looked at showed there was a rolling programme of training in place which included the Care Certificate, moving and handling, personal safety, safeguarding, mental capacity, medicines administration and dementia awareness. The Care Certificate is a nationally recognised qualification for health and social care workers. In addition to core training we saw supervisory staff such as care co-ordinators and team leaders also received training in team management and leadership.

People we spoke gave good feedback about the staff's skills and knowledge. One person told us, "I've had this agency for five years; there are excellent carers I cannot find fault with." Another person said, "I can't praise them enough for their attention to detail." We saw evidence there was a proactive approach to training in the service, including a 12 week induction programme and regular updates to training to ensure staff knowledge was kept up to date.

Staff we spoke with told us they had regular training and were regularly spot-checked by care co-ordinators who observed their work and gave feedback. One member of staff said, "I had quite a while when I shadowed a more experienced member of staff, and I had to complete my training. I did not work alone until we all felt I was ready." Another staff member said, "We have plenty of training, and a lot of it is in a classroom. We all had to go in a hoist when we did moving and handling training, so we know what it feels like." We saw all staff had a formal appraisal at the end of the 12 week induction to ensure they were ready to begin work as a member of the care staff.

Records of appraisals showed these took place annually with all staff, and we saw conversations were recorded in areas such as staff's understanding of their role, key achievements, what they liked and disliked about the organisation, any additional training and qualifications people were interested in and aims for the coming year. Staff we spoke with told us they felt these were valuable meetings at which they felt free to speak openly about their experience of working for the provider, and said that where additional training was requested this was organised for them.

In the PIR the provider told us, 'Registered Manager carries out one to one review meetings with team leaders every four weeks to assess workload and any support needs.'

We saw records which confirmed staff were regularly visited whilst on calls by care co-ordinators who observed their practice and gave feedback. A staff member said, "They come out and assess us on a regular basis." Staff we spoke with confirmed these visits were regular and said they could speak to their care co-

ordinator at any time if they had any concerns. They also told us they had an annual appraisal at which their performance, training needs and objectives for the next year were discussed. We did not see records of formal supervision meetings taking place in the format and at the intervals defined in the provider's policy. The policy stated, 'Supervision time must be balanced, protected and uninterrupted. Sessions should be held in private. At the staff member's annual appraisal the format and frequency of supervision should be discussed , reviewed and amended as necessary to meet the needs of individual staff.'

We discussed the approach to supervision with the operations manager and team leader. We agreed there had been a misunderstanding about the term 'supervision', saw there was monthly face to face contact with all staff, including one-to-one meetings between the registered manager and team leaders. This had been seen as meeting the needs of formal supervision by the management team in the service. The operations manager carried out a review of supervision activity in the service during the inspection and said they would ensure formal supervision meetings took place in future.

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.

Staff we spoke with about people's mental capacity understood some people may need assistance to make decisions and told us how they offered choice to ensure the person's wishes were respected. One member of staff said, "We always assume people have capacity unless we are told otherwise." Another told us, "We offer choice when helping people choose what to wear and what to eat. The client chooses what to do." Staff told us if they felt there was a change in people's ability to make decisions they reported this to the care co-ordinators.

The operations manager told us they did not always receive information relating to people's capacity to make decisions when services were commissioned from them. They said, "Sometimes it is only when we go to meet people to start writing their care plan that we realise people may lack capacity and we might have to involve others to help them make decisions, or a staff member alerts us to a change in people. At this point we would ask to social work team to visit the person to carry out a formal capacity assessment." Staff told us they had training in the MCA and records we looked at confirmed this
.
We saw people signed a customer agreement and gave consent to staff spot checks in their home and administration of medicines.

Care plans did not always contain information which showed us whether any referral for a capacity assessment had been made. For example, in one care plan we saw in the 'awareness, memory and confusion' section staff had recorded about the person, 'My memory is poor due to having dementia. I do get confused. I am not always fully aware.' It was not clear which decisions the person may lack capacity to make or that any assessment had been planned. We discussed improving the evidence of this process with the operations manager and team leader during the inspection and they told us this was something they would improve.

Staff told us people were offered choices at mealtimes. They told us they promoted healthier eating but respected people's choices. One member of staff said, "We try and encourage a healthy meal. I peel fruit for [name of person]." Another staff member said, "I generally try to persuade people to eat their vegetables."

Good

Is the service caring?

Our findings

People we spoke with were very complimentary about the care staff and the provider's service. Comments included, "I have them four times a week and wouldn't be without them, there are lovely girls", "I can't sing their praises high enough", "My regular carer is kind and good and I'm so grateful for her friendship. She looks after me so well," and "I look forward to the carers coming."

The report produced after the customer satisfaction survey in May 2016 contained quotes from people who used the service, and we saw a range of compliments had been given. Comments included, 'I feel that receiving home care from Springfield has improved my way of living. Well done,' 'All round excellent, they are like friends and they think of little things as well as basic care,' and '[Name of person] is very pleased with the carers who come to bathe her, she is very complimentary about them. They are a credit to your organisation.'

Staff spoke about people with fondness and respect, and were able to tell us in detail about the likes and dislikes and care needs of people who they supported. The provider's training consultant told us, "We embed relevant parts of the Human Rights Act and respect for diversity in all our training. We teach people that everyone deserves the same." One person who used the service told us, "My carer makes me feel valued when I get depressed."

Care plans contained some basic information about people's lives, people who were important to them and their hobbies and interests. This demonstrated that people had been consulted during the process of writing their care plans. Staff we spoke with said they got to know people well, and people who used the service told us they had a good relationship with the staff. One person who used the service said, "I feel they really care about me in every respect."

We saw spot checks included monitoring staff's approach to privacy and dignity, and people told us this was respected. One person said, "They are very nice girls who treat me with respect and affection." Staff we spoke with gave examples of how they worked to ensure this was the case. One member of staff said, "I make sure curtains and doors are closed, and I always ask people before I do anything for them." Care plans we looked at showed how people's independence should be promoted. For example, one care plan stated, 'Prompt me to wash, but offer assistance if I am unable to complete the tasks myself'. Another stated, 'If carers can just put the shower gel on the sponge and pass it to me and put the shampoo into my hand so I can wash my hair that would be fine as I try and remain as independent as possible.'

Requires Improvement

Is the service responsive?

Our findings

In the PIR the provider told us, 'Any changes to care needs are responded to immediately and a review meeting is arranged. We report any concerns to social services regarding customers that we feel are at risk of becoming isolated. We acknowledge and deal with concerns immediately, being pro-active ensuring that issues are not left to develop/escalate further in to a complaint. If a complaint is received, an acknowledgement is sent; investigations are carried out and dealt with within the 28 day period.'

Care plans contained a pre-assessment which showed how the provider ensured they could meet people's care and support needs before they commenced using the service. We saw care plans were regularly reviewed to ensure they continued to reflect people's up to date needs, however, these reviews were not always signed by people to show they had participated in the process or agreed with the contents. Staff we spoke with told us they had regular updates when people's care needs changed. One member of staff said, "We have monthly meetings where we discuss our clients, and the care co-ordinators will always be in touch if something changes in between the meetings." Staff told us they would alert the office if they saw or were told someone's needs had changed. One staff member gave us an example. They said, "If we felt that a call needed to be longer to do what the person needed we would report this to the office, and they would ask social services to increase the call time."

Spot checks of staff carried out in people's homes included asking the people who used the service if they were happy with the way the staff worked and whether they were happy with the service. This meant people had regular opportunity to request changes and give feedback.

Although staff were able to tell us about how they provided care in ways which people preferred, much of this information was not documented in people's care plans. A summary page described outcomes for people, such as maintaining independence, improving quality of life and choice and control. In six of the care plans we looked at this information was identical. A further two care plans contained identical summary information. This meant information was not always person-centred. Person-centred care planning means involving people to ensure their care plans are individualised. We brought this to the attention of the operations manager during the inspection, and they agreed this was an area they would improve.

People we spoke with had not had any experience of making complaints. All told us they were highly satisfied with the service they received. The provider had policies and procedures in place to ensure complaints and concerns were recorded and thoroughly investigated. We looked at records of complaints received and saw evidence of meetings held to gather information from staff who may have been involved with any incident, contact and meetings with the people who made the complaint to explain the process, clear delegation to show how the regional management team and provider would be involved and contact with external bodies such as social services which demonstrated the processes were thorough and transparent. When an investigation was complete we saw there was an update to the person who had raised the concern.

Requires Improvement

Is the service well-led?

Our findings

In the PIR the provider told us, 'Our branch has a registered manager, and two team leaders who manage and communicate and have a consistent approach in order to effectively manage the team. They have key responsibility for their own teams, ensuring regular and consistent communication and performance management. We have daily huddle meetings, weekly team meetings, regular carer meetings to keep everyone aware of operations of the branch. In addition we attend monthly regional manager meetings, and provide weekly targets to the regional team and senior management team to be transparent in key areas such as hours, staffing, recruitment, complaints, HR issues etc. The team leaders are in place to work closely with the supervisors to make sure reviews/observations/spot checks are carried out, and quality standards are met. They have weekly targets/objectives that are monitored weekly as part of their ongoing performance management.'

There was a registered manager in post on the day of our inspection; however, they were on annual leave on the day of our inspection. The provider's operations manager attended to support the team leader with the inspection.

We looked at the processes in place to measure, monitor and improve the quality of service being provided, and the policy in place to describe how these activities would be carried out. We found the policy was generic and lacked detail. For example, when we looked at the 'audit structure' section it stated, 'Our audit frequency codes reflect the activity of [Anonymous Care Ltd.], and are proportionate to our service delivery.' We saw there were codes in place for annual, quarterly, monthly, weekly and 'randomly' conducted audits; however, the policy had not been updated to remove the generic company name or show what activities were expected at which frequency. In addition the policy stated, 'Each and every audit must be completed, signed and dated by the designated post holder who is named below, within the frequency coding timescales.' There was no information added to show who was responsible for conducting audit activity.

We talked to the operations manager about the audit activity they expected the registered manager to carry out and what reports they received. They told us they received a weekly 'snapshot' report which included operational information, activity around recruitment and service capacity and a 'quality overview'. In addition there was a weekly branch review discussion which covered sickness and absence, current complaints, staff meetings and any other issues emerging. They told us a new framework was due to be introduced which would re-define audit activity in the service.

We saw limited evidence of audits taking place, however, it was not clear how this activity contributed to driving quality in the service or how issues identified were reported and rectified. For example, we saw some daily notes had been audited; however, there was a lack of actions identified and no overall analysis of how well daily notes were completed. The team leader told us, 'Forms are given back to care co-ordinators for review and action.' Similarly some MARs had been audited, but issues were not always identified, no action plans were produced ad there was no analysis which would contribute to understanding the quality of the service and driving improvements in the service.

We concluded the provider did not have a robust audit policy or quality monitoring systems in place. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008, (Regulated activities) regulations 2014.

People who used the service were all highly complimentary about it and said they would recommend it to other people. One person said, "They are both wonderful the carers and the agency. I love these dependable people." Another person told us, "I've been with them for two years now and this agency are chalk and cheese different from other agencies I have used. These people are courteous and polite, both agency and carers. I was told most of the people in the office had been carers themselves, it shows." A relative of someone who used the service told us, "[Name of person] is totally content. She would let me know or the agency if she were not. Communication with the agency is fine. We have been with them a number of years and know the girls in the office.''

Staff we spoke with gave good feedback about the leadership in the service. One member of staff told us, "[Name of registered manager] makes things happen. She gives a clear message. She has been a carer before so knows how it is for us." Another staff member said, "[Name of registered manager] is very approachable. She listens and acts on what she is told."

We saw evidence of staff meetings taking place regularly, and staff we spoke with told us they felt they could speak freely and were included in discussions about the service. One member of staff told us, "We have team meetings monthly, we can discuss any issues we have and these get resolved." People who used the service had the opportunity to give feedback about the service during spot checks and observations carried out on staff in their homes, and also through an annual survey. We looked at the results of the most recent survey, conducted in May 2016 and saw a range of questions had been asked including whether staff followed care plans, whether staff arrived on time, whether people had found the out of hours helpline useful and whether cultural or religious needs were respected. We saw the results indicated a high degree of satisfaction with the service. An action plan to address any deficiencies had been written, with clear delegation of responsibility and timescales.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's audit policy was generic and incomplete. There was not sufficiently robust audit activity in place to measure, monitor and improve quality in the service.