Insignia Healthcare Solutions Limited

Insignia Healthcare (Norwich)

Inspection report

10-14 Plumstead Road East
Thorpe St. Andrew
Norwich
Norfolk
NR7 9NE

Tel: 01603952626
Website: www.insigniahealthcare.co.uk

Date of inspection visit:
22 August 2017

Date of publication:
12 October 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was announced and took place on 22 August 2017.

Insignia Healthcare (Norwich) was registered by the Care Quality Commission (CQC) on 3 December 2015. New services are assessed to check they are likely to be safe, effective, caring, responsive and well-led. This was the first comprehensive inspection since the provider registered with CQC to provide personal care to people. As such, they had not yet received a CQC rating.

Insignia Healthcare (Norwich) is a domiciliary care agency which provides personal care to people with a variety of needs including older people, people living with dementia, younger adults, people with a learning disability, physical disability and people who need support with their mental health. The agency's office is located in St. Andrew, Norwich. At the time of our inspection, the service was providing personal care to 19 people.

There was a registered manager in post who was also the provider of the service. 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. In this report when we speak about both the company and the registered manager, we refer to them as being, 'the registered persons'. The provider had recently appointed a manager with the intention they become registered and manage the service on a day to day basis. They had also submitted an application to register with the Care Quality Commission (CQC).

People and healthcare assistants spoke highly of the care co-ordinators and the company. People expressed satisfaction with the service they received. However, the provider had found that quality assurance systems were not always being used to ensure accurate records were maintained and to drive improvements. The provider had implemented computer software 10 days prior to the inspection to improve this, however we will need to assess how this improvement has been embedded and sustained at our next inspection. We found no evidence that the lack of audits and gaps in records had impacted on the quality of service people received.

Risks to people's wellbeing and safety had been effectively mitigated. We found individual risks had been assessed and recorded in people's care plans. Examples of risk assessments relating to personal care included moving and handling, nutrition, falls and continence support. Health care needs were met well, with prompt referrals made when necessary.

People told us they felt safe receiving the care and support provided by the service. Staff understood and knew the signs of potential abuse and knew what to do if they needed to raise a safeguarding concern. Training schedules confirmed staff had received training in safeguarding adults at risk.

Robust recruitment and selection procedures were in place and appropriate checks had been made before staff began work at the service. This contributed to protecting people from the employment of staff who were not suitable to work in care. There were enough staff to protect people's health, safety and welfare in a consistent and reliable way.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed safely.

The management team and staff had an understanding of the Mental Capacity Act 2005 and consent to care and treatment.

People chose their own food and drink and were supported to maintain a balanced diet where this was required.

People said staff were caring and kind and their individual needs were met. Staff knew people well and demonstrated they had a good understanding of people's needs and choices. Staff treated people with kindness, compassion and respect. Staff recognised people's right to privacy and promoted their dignity.

We looked at care records and found good standards of person centred care planning. Care plans represented people's needs, preferences and life stories to enable staff to fully understand people's needs and wishes. The good level of person centred care meant people led independent lifestyles, maintained relationships and were fully involved in the local community.

There was a complaints policy and information regarding the complaints procedure was available. There was one complaint in the past 12 months. Records demonstrated this was listened to, investigated in a timely manner, and used to improve the service. Feedback from people was positive regarding the standard of care they received.

Staff felt supported by management, they said they were well trained and understood what was expected of them. Staff were encouraged to provide feedback and report concerns to improve the service.

The provider had developed an open and positive culture, which focused on improving the experience for people and staff. The provider welcomed suggestions for improvement and acted on these.

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 had detailed care plans, which included an assessment of risk. These contained sufficient detail to inform staff of risk factors and appropriate responses.

People were supported by trained staff who knew what action to take if they suspected abuse was taking place.

There were enough staff to cover calls and ensure people received a reliable service. Safe recruitment systems were in place.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had received training and supervision to carry out their roles.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

Staff protected people from the risk of poor nutrition and dehydration.

People had their health needs met and were referred to healthcare professionals promptly when needed.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who knew them well. People involved in all aspects of their care and in their care plans.

People were treated with dignity and respect by staff who took

the time to listen and communicate.

People were encouraged to express their views and to make choices.

Is the service responsive?

Good

The service was responsive.

Care plans provided detailed information to staff on people's care needs and how they wished to be supported.

People's needs were assessed prior to them receiving a service.

People were provided with information on how to raise a concern or complaint.

Is the service well-led?

Good

The service was well-led.

The provider had recently changed their quality assurance processes too fully monitor the quality of service provided and to ensure robust records management. We will need to assess how this improvement has been embedded and sustained at our next inspection.

There was an open and positive culture, which focussed on providing high quality support for people.

Staff were supported and listened to by the provider. They were clear about their responsibilities.

Insignia Healthcare (Norwich)

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 22 August and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to ensure that someone would be available.

The inspection team consisted of one inspector and an expert-by-experience with experience in adult social care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete 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. Due to technical problems, a PIR was not available and we took this into account when we inspected the service and made the judgements in this report. We looked at the notifications and other intelligence the Care Quality Commission had received about the home. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events, which the service is required to send to us by law.

During our inspection, we went to the office and spoke with the provider who was also the registered manager. We also spoke with the deputy manager, a senior care coordinator, two care coordinators, two healthcare assistants and the education officer. The expert-by-experience made phone calls to one person and four relatives to request their feedback about what it was like to receive care from the staff at Insignia

Healthcare (Norwich). They agreed for their comments to be included in this report.

We reviewed the care records of five people receiving support. We looked at service records including four staff recruitment, supervision and training records. Policies and procedures, complaints and compliments records and records of checks that had been completed to monitor the quality of the service being delivered.

Good

Is the service safe?

Our findings

People told us they felt safe receiving support from Insignia Healthcare (Norwich). The following examples were given as to why people felt safe. One person said, "We've been lucky. We've had three main carers since we started the service.' Another person told us they felt safe because, "It's regular staff."

People were protected from the risk of abuse because staff understood the different types of abuse and how to identify and protect people from the risk of abuse or harm. Safeguarding policies were in place with additional policies on entering and leaving people's homes, handling their monies and property, confidentiality and dealing with emergencies. Policies provided underpinning guidance for staff to follow. Training records showed all staff had attended safeguarding training annually. Staff told us all concerns would be reported to the provider. If concerns related to the provider, they would report them to the appropriate local safeguarding authority or the CQC. The care co-ordinator told us, "Safeguarding means to protect people we support from harm. If an allegation of abuse were made, I would contact the person to gain more information. I would complete an alert to the safeguarding team and you [the Commission]." One member of staff told us "I would report to the manager, document what I knew and make sure it had been reported to safeguarding and CQC."

Risks to people's wellbeing and safety had been managed effectively. We found individual risks had been assessed and recorded in people's care plans. There were comprehensive risk assessments, which covered the internal environment of the person's home, risks of falls, nutrition and hydration, and continence information. Visual checks were completed on equipment such as bathing and shower equipment. Additional risk assessments were completed in relation to people's specific needs. For example, one person had moving and handling needs. The assessment identified that two care workers were required to assist the person safely and this was provided. There was sufficient guidance for staff to support the person safely. The care plans were reviewed if there were any changes in the person's care needs. This helped to ensure staff had access to up to date information about supporting people safely.

Accidents and incidents were recorded and the provider was informed if there had been any incidents. Staff told us they understood the process for reporting and dealing with accidents and incidents. If one occurred, they would inform the office staff and an accident form would be completed. We looked at the accidents and incidents for 2016 and 2017. These records clearly stated what actions were taken to keep the person safe. However, the provider was unable to show how they analysed and learnt from accidents and incidents. We found that the nature of accident and incidents that had occurred were not repeated ones and therefore found this had not impacted on people's safety. We have written about this in the well led domain.

There were sufficient staff to meet people's needs safely. People told us that they felt there were enough staff and that the care/support was provided in a timely manner. Staffing levels matched what was planned on the staff rota system. People told us their care worker arrived on time and that they were informed if there were any delays. The office was open between 9am and 5pm from Monday to Friday with on-call cover 24 hours, seven days a week, in case of an emergency. We spoke to two staff who told us, "We never do less than hour long calls. That means we have time to make our visit personal. It's not rushed." "I know that it's a

problem with other agencies but I can honestly say I've never felt under pressure."

People were protected, as far as possible, by safe recruitment practices. Staff files confirmed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk.

People's medication administration records (MAR) were accurate and clear. Staff received medicines training and were able to describe how they safely supported people with their medicines. Training records confirmed that all staff received medication training. Medicine assessments considered the arrangements for the supply and collection of medicines. They included whether the person was able to access their medicine in their own home and what if any risks were associated with this. Staff were aware of the provider's policies on the management of medicines and followed these. Staff had a good understanding of why people needed their medicines and how to administer them safely. MAR charts contained clear guidance about the use of medicines prescribed for occasional use, such as for pain relief or anxiety.

Good

Is the service effective?

Our findings

People told us staff were competent to meet their needs. One person told us "They [staff] are well trained." A relative told us, "Yes I think so [staff being appropriately trained for the care they need to deliver]. It can take a little while to get used to [person] but they are very good."

All new staff completed an induction, which included all generic and specific training to enable staff to carry out their role. They shadowed staff that were more experienced and did not work on their own until they were competent and confident to do so. New staff were enrolled on the Care Certificate (Skills for Care). The Care Certificate is a work based achievement aimed at staff who are new to working in the health and social care field. It offers an opportunity for providers to provide knowledge and assess the competencies of their staff. The Care Certificate covers 15 essential health and social care topics, with the aim that this would be completed within 12 weeks of employment. Staff were also encouraged to complete various levels of National Vocational Qualifications (NVQ) or more recently Health and Social Care Diplomas (HSCD). These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

Staff received training which the provider considered as mandatory. This included food hygiene, infection control, health and safety, first aid, moving and handling, and in the Mental Capacity Act 2005 (MCA). Training was refreshed as needed and certificates in staff files confirmed the training staff had completed. It was also mandatory to complete 'delivering personal care' training for females and males. Additional training was provided for staff to meet people's specific needs such as mental health awareness, dementia awareness, fluids and nutrition and falls training.

The provider's training room was arranged to re-create the conditions staff might experience in people's own homes, staff referred to this as the 'mock up' room. This included using a hoist to support somebody with moving and handling in a cluttered small space. It included supporting someone's personal care in the bathroom which was being used for storage. A staff member told us, "The mock up room is brilliant. Doing training in a sterile room with loads of space isn't what we encounter every day. So having the mock up room to practice our skills in is much better. It really prepared me for the support we give to people in their own homes." The education officer told us, "The atmosphere here is brilliant. To have the opportunity to give staff the best training to deliver the best quality care, to be confident in their roles, is what I set out to do."

Staff received regular supervision and appraisals; this gave staff an opportunity to discuss people they were supporting, their own support needs, areas for development and any further training. Staff also received a 'Spot Check' when they were observed by the care co-ordinator, working directly with people. During a 'Spot Check' staff competencies were observed in relation to the support provided. Records demonstrated the care co-ordinator gave staff feedback on the spot if anything could be improved to their practice.

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 told us they felt involved and that their views and decisions were respected by staff. Care plans contained mental capacity assessments. Staff had a good understanding of mental capacity and put this into practice to ensure people's rights were respected. A staff member told us, "I have done some training recently [on MCA]. People have choices and should be able to make their own decisions. This should be assumed unless assessed otherwise." Another staff member told us, "There are some choices that are risky, but that is an individual's choice. People can make unwise choices and these are reflected in people's care plans. A person we support does not agree with medical intervention, which is respected. People's capacity should be assumed."

Professionals from the local authority had completed MCA assessments for people when necessary for people who lacked capacity to agree to the care provided. During this process, a record was also maintained of best interest decision making processes that involved people who were involved in the person's life. Assessments were decision specific and were in line with the MCA code of practice.

People told us that where it was a part of their care package, staff supported them to eat and drink enough. The support people received varied depending on people's individual circumstances. Some people lived with family members who prepared meals. Staff reheated and ensured meals were accessible to people who received a service from the agency. Records demonstrated other people required greater support which included staff preparing and serving cooked meals, snacks and drinks.

Staff supported people to access advice about their health and welfare. The care plans included key contact details of people's next of kin, social worker, GP, district nurse and relatives. People with more complex needs had additional contact details of healthcare professionals such as occupational therapists, dieticians and the Speech and Language Therapy (SALT) team. Staff said and records confirmed, that any changes in a person's behaviour or if someone was ill when they arrived would be reported to the office immediately to obtain advice and support from relevant healthcare professionals.

Good

Is the service caring?

Our findings

People and their relatives told us they were treated with kindness and respect by the care workers who supported them. One relative told us, "They [staff] do that little bit extra. For example, if it's our wedding anniversary they'll remind [person]." Another relative told us, that if the person has been distressed "they'll soothe him until he's calmed down."

People said they felt comfortable with their care workers, and were treated as individuals. Staff knew people well; they had a good understanding of people's needs, choices, likes and dislikes. One staff member told us, "We're given the time to get to know people." Another staff member told us, "It's a very caring place to work."

People told us that they were involved in planning their care on a day to day basis and that staff listened to them. People told us they were given choices on a daily basis for example, how they wanted their care to be given and what they wanted to eat or drink. Staff were given enough time to get to know people who were new to the service and read their care plans and risk assessments. Staff told us, although they knew what care people needed, they continually asked people what they wanted. Records demonstrated that people were consulted and participated in their care plans. People were provided with opportunities to talk to staff about how they felt on a daily basis. People had allocated staff members who helped them achieve their goals, created opportunities for different activities and advocate on behalf of the person with their care plan. People told us that their care plans were kept in their property and that they could look at it anytime.

To ensure that all staff were aware of people's views and opinions, they were recorded in people's care plans, together with the things that were important to them. Without exception, staff told us that it was important to promote people's independence, to offer choices and to challenge people where needed help them achieve their goals. People told us they felt the service was appraised of their views, be that via calls or reviews.

Each person had a communication care plan, which gave staff practical information about how to support individual people who could not easily speak for themselves. The care plan gave guidance to staff about how to recognise how a person felt, such as when they were happy, sad, anxious, thirsty, angry or in pain and how staff should respond. People told us staff communicated with them in an appropriate manner according to their understanding.

Staff promoted people's privacy and dignity. Care plans contained guidance on supporting people with their care in a way that maintained their privacy and dignity and staff described how they put this into practice. All staff members we spoke with told us how they would draw people's curtains before supporting them with personal care. Staff we spoke with told us that it was important to ensure people had the privacy they needed and that they had their own space. The care co-ordinator told us, "We need to be mindful of closing doors and curtains. Put a blanket over the person's legs to cover the person while doing personal care. Reassure the person and making it clear what we are doing and involving them as far as the person is able, in the process."

Good

Is the service responsive?

Our findings

People were involved in decisions about their care and support and in reviewing their care needs. One person said, "It works well and I feel very involved." A relative told us, "I am definitely involved and we've just updated it [care plan] again."

People's needs had been assessed before they began using Insignia Healthcare (Norwich). People said the care plans reflected their support needs. The provider told us the assessments were carried out to ensure the service could provide the support people needed and they were used as the basis for the care plans. Care plans included a detailed assessment of people's needs and included people's preferences and routines. They had been completed with each person and their relatives where appropriate. Staff were able to provide examples of how they provided personalised care and support, which responded to people's needs.

Care plans were informative, comprehensive, and included people's religion, medical histories, social histories, health details and medical condition. Each care plan had additional policies, guidance and best practice documentation, which related specifically to the person's condition such as 'diabetes' guidelines. Daily care records reviewed showed that staff delivered the care each person required.

Care plans showed that people had been involved in their care planning. Reviews were completed where people's needs or preferences had changed and these were reflected in their records. This showed that people's comments were listened to and respected. One member of staff told us, "We involve families if the person wants to." A relative told us, "The reviews are very good and very thorough."

People said staff arrived on time and no one we spoke with had experienced missed visits. The provider told us they informed people if staff were likely to be late. Staff told us they felt supported by the office staff and by the information available in people's homes, which included the care plan, daily notes, protocols and guidance. Without exception people indicated that they felt communication with the agency was respectful.

People were provided with a 'Service User Guide' which contained information about the provider, including the values and who to contact with any questions they might have. All of the people we spoke with confirmed they knew who to contact at the service if they had queries or changes to their care needs.

People knew how to make a complaint and felt that they were listened to. The procedure to make a complaint was clearly outlined in the complaints procedure and the 'Service User Guide', which had been sent out to all the people who used the service. There had been one formal complaint in the past 12 months. Records demonstrated this was listened to, investigated in a timely manner, and used to improve the service. Feedback from people was positive regarding the standard of care they received. One relative told us, "If ever I've phoned up about anything, it has been resolved to my satisfaction."

Good

Is the service well-led?

Our findings

The provider is also the registered manager and for the purposes of the report is referred to as provider.

The provider's systems for monitoring quality and safety were not fully effective in addressing areas for improvement. There were monthly audits and these included care plans, staff files, medicines and training. However, where shortfalls were identified, there was a lack of detail regarding the action taken to address this and how it was followed up at the next audit to check it had been completed appropriately. For example, the daily notes were audited and the tool indicated that some errors had been made, but did not detail the nature of error and action taken. The provider was unable to show how they analysed and learnt from accidents and incidents. We found that the nature of accident and incidents that had occurred were not repeated ones and therefore found this had not impacted on people's safety. We found no evidence that the lack of audits and gaps in records had impacted on the quality of service people received. The absence of detailed and recorded auditing meant the provider could not be assured of the quality of service delivered. The provider told us this was an area they had already identified as needing improvement. The provider showed us computer software which had been implemented 10 days before the inspection which included systems they had created to address this. We will need to assess how this improvement has been embedded and sustained at our next inspection.

The provider was an active presence in the organisation and spent a lot of their time visiting the people they supported and providing clinical advice to staff. They were responsible for undertaking an initial assessment to decide if the organisation could support a person safely in a community setting. They had set up the company because of their passion to provide people with a home in the community with the right support. People referred to him as being very approachable and always available when in the office. Staff told us his door was always open and we observed staff feeling comfortable enough to enter the office and talk with him when they needed to.

The staff team knew each other well and worked as part of a supportive team. A staff member said, "I've worked here for a few years now. I think it's very well led." The care co-ordinator told us, "The vision and values are to provide high quality care to all people supported, to meet their individual needs. Respecting their dignity, promoting support where necessary and to offer continuity in seeing the same regular staff." The provider gave awards annually to staff, who were nominated by their peers, relatives and people they supported. These awards included 'Carer of the Year', this was awarded to one staff member who had excelled in their field, made progress professionally and received positive feedback. In addition, the provider also awarded 'carer of the month'. The award was a voucher, certificate, letter of recognition and their name on the radio each month. Staff told us this really made them feel valued.

There was an open and positive culture which gave staff confidence to question practice and report concerns. The provider told us that staff meetings were held as and when needed. However, on a daily basis the staff had access to a secured online 'jotter' and 'pop up messages' from the care coordinators and provider regarding any updates in policies / care plans that staff needed to be aware of. We looked at the minutes from June to August 2017. Discussion included people's needs, safeguarding, MCA and DoLS

practice, new policy and procedures, staff sickness, staff holiday, and professional conduct.

A 'Spot Check' took place every three months whereby unannounced checks were made on staff when they were delivering care in people's homes. During these visits, people were asked their views about the care they received and their views were documented. All views and comments were positive.

Monthly one to one meetings took place. This is when an allocated staff member meets with the person each month to discuss their views on the care they received, activities they would like to do in the future and discuss any changes occurring in the service, for example, staffing. This empowered people to contribute towards decision-making and make choices.

The provider sought feedback from people through monthly questionnaires to aid the strategic development of the service. These questionnaires had last been sent to people in July 2017 and the responses from people had been consistently positive and no areas for immediate development were identified.