Harcombe Valley Care Limited

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Inspection report

Trusley
3 Manstone Close
Sidmouth
Devon
EX10 9TZ

Tel: 01395513222
Website: www.harcombevalleycare.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 22 and 29 November 2016 and was announced. The provider was given notice of the inspection on 18th November because the location provides a domiciliary care service and we needed to be sure that someone would be in. The last inspection took place on 15 January 2014 and no concerns were identified with the five standards inspected.

Harcombe Valley Care Ltd is a small domiciliary care service registered to provide care for people living in their own homes. It is a family business in Sidmouth, in which the manager employs her two daughters as assistant managers. The business provides both domestic care and personal care to people living in and around Sidmouth. At the time of the inspection, there were 45 people receiving the service, of whom 37 people received personal care. Personal care includes assistance with eating food and monitoring fluids, washing hair, teeth, shaving, bathing, showering and administration of medicines and creams. We only looked at the service for people receiving personal care, as this is the regulated activity that is registered with the Care Quality Commission (CQC).

In addition to the three managers, there were 17 care assistants, two of whom were senior care workers , (one of these being an office administrator) and five bank care staff. Times of visits ranged from 30 min to 1 hour, with occasional overnight sleeping duties. The frequency of visits ranged from once a week to several times every day of the week. The owner of the service was also the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People using the service said they felt safe whilst being cared for by Harcombe Valley staff in their own homes. They liked being informed in advance who was coming and there was no evidence of any missed calls. One person said, "They send out a list [of care assistant names] every weekend and they come on time." One person liked the fact that this was a family business because "Those managing the business are themselves experienced carers who know their clients and take part in caring themselves." People felt that the care provided to them was good and this was confirmed by other healthcare professionals who praised the service for being responsive and proactive.

The service had trained staff in the principles and practice of safeguarding. Risks to individuals were managed by a series of risk assessment processes. This included assessment of the environment in each person's home. Records were kept in each person's care plan and reviewed regularly. Spot checks were undertaken to ensure that staff were adhering to safe principles in moving and handling and use of equipment. Staff are aware of signs of potential abuse and were aware of how to respond. Records were kept of incidents and accidents and learning from them was disseminated to care assistants. When there were issues, they had been responded to promptly by management until resolution was reached. Staffing levels were kept safe by not taking on new people if staff numbers could not support this. People received

assistance in taking medicines and creams from staff trained to administer medicines. External consultants advised on all health and safety issues and undertook annual audits.

The service had undertaken all the necessary checks before employing people to ensure they were suitable to be care assistants. There was a system of mandatory training in place for all care assistants which was regularly reviewed.

Staff had the opportunity to update their knowledge at regular intervals and were supervised regularly. A lack of understanding of the full implications of the Mental Capacity Act 2005 was evident on day one of the inspection, but by day two of our inspection a training session had been devised and a date fixed to commence delivery on a rolling programme and a new assessment form was planned..

People said they had their informal concerns and complaints addressed in a timely manner, but nobody had needed to use the formal complaints policy. The service is looking at new ways to gain anonymous feedback from service users in order to make their quality assurance systems more robust. One member of the management team expressed their vision for the business in the follows, "We want to keep moving forward and improving, always trying to be one step ahead."

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.

Staff knew how to recognise and report any concerns so that people could be kept safe. People using the service said they felt safe.

Risks to people's well-being and safety were being assessed, recorded, managed and regularly reviewed.

The service had sufficient staff to keep people safe and meet their needs.

The recruitment process was robust with all required information and documents always obtained before staff began to work unsupervised.

People received their medicines on time and safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always aware of the implications of the Mental Capacity Act 2005 on their work but immediate steps were taken by management to remedy this by training. This meant that the correct procedure had not always been followed for some people who lacked capacity.

Staff received training, supervision and ongoing support which helped them to meet people's needs appropriately but adequate records were not always kept.

People were supported to have sufficient to eat and drink.

Is the service caring?

Good

The service was caring.

People using the service confirmed that care workers treated them with dignity and respect.

People were able to have the individual choices and needs for privacy protected.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed on an individual basis in detail before care commenced. Care plans were regularly updated as changes occurred.

People knew how to raise concerns and complaints informally and were given information about how to complain formally.

The service had investigated concerns and informal complaints and devised improvement actions.

Is the service well-led?

Good

The service was well led.

The management team was well organised with clear roles.

Staff felt valued and supported by a committed management team.

Quality assurance systems had identified some improvements needed to the service.

Plans were put in place to gain anonymous feedback from service users to ensure feedback about the service was accurate.

Harcombe Valley Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 November 23 and 29, 2016. The inspection was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. The service is small and the registered manager is often out of the office supporting staff or providing care. We needed to make sure they would be available during the inspection. The inspection team consisted of two adult social care inspectors on the first visit and one adult social care inspector on the second visit.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is the 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 also reviewed information about the service. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to tell us about by law. Before the inspection we had received concerns about poor staff practices and staff deployment. As part of the inspection we looked at these concerns and found no evidence to substantiate them.

Before our inspection we sent questionnaires to people who use the service, their relatives and friends, staff and health care professionals. This was to gain their views about the service. We received responses from 12 people who use the service or their relatives

We spoke on the phone with 5 people who were using the service or their relatives and two visiting health and social care professionals involved in people's care. We also spoke with the provider and the registered

manager on both visits at the office. During the inspection we spoke with seven members of staff, either face-to-face or on the telephone.

We reviewed two care plans in depth and other care records. We also reviewed training records, four staff recruitment and support files and records which related to the management of the service, such as competence observation forms.

Good

Is the service safe?

Our findings

People who used the service said they felt safe with staff, that staff were competent and did not rush them.

Staff said they had received training about safeguarding people and were able to describe some of the types of abuse people may be exposed to and what they would do if they found evidence of abuse. They knew they had to report any concerns to the registered manager and said they were confident action would be taken about any concerns which they raised. They also knew they could report concerns to other organisations outside the service if necessary. One member of staff said, "we had training and we have a handbook." The registered manager confirmed that on one occasion she had received information from a staff member about unacceptable practice towards a person using the service by another member of staff. This had been tackled directly with the staff member who was given training in the correct procedure.

Before the inspection we received information of concern relating to two people using the service. The allegations were investigated by the local authority safeguarding team. The safeguarding team decided there was insufficient evidence to take safeguarding action. The service discussed the action they had taken to investigate this incident, which included talking to people using the service and other staff. They found no evidence to substantiate the allegation.

An independent health and safety consultancy was employed to undertake an annual review of health and safety issues and an audit of risk assessments. As a result of this the organisation had improved the documentation they used.

Each person had an individualised, highly detailed risk assessment relating to the delivery of their care. Information from the initial assessment was then included in people's care plans. This covered infection control, clinical waste, general household rubbish, nutrition and dietary handling, COSSH (dangerous explosives substances such as oxygen), animals, and fire safety. The service had RCD (residual current device) adaptors which they could use if a concern was identified regarding someone's electrical equipment which staff were required to use.

Specific guidance was available for staff to follow in order to minimise risks. For example, where moving and handling posed a risk, or if the person was at risk of falling. Industry-standard assessment tools such as the Braden scale, for pressure ulcer prevention risk assessment, were used. This meant staff were aware of the potential areas to monitor and care plans were written to address those risks. Care records also contained environmental risk assessments which helped to identify any potential risks in the person's home that might affect the person or staff, such as loose rugs which were a potential trip hazard. The registered manager said, "If we spot hazards [in a person's home] we log it then talk to the service user about it." People were encouraged to consider having key safe boxes so that keys were accessible in case of emergencies. Spot checks on visiting care staff included whether they were securing the premises before leaving where required. People confirmed that staff wore a uniform and name badge so they could be confident staff worked for the company before letting them enter their home. People needs/risk factors had been assessed and given a grade to indicate priority need in case of emergency, for example, in bad weather or if staff

member was sick. This meant those living alone with no relatives nearby would be prioritised.

Staff said they had been shown how to use equipment in people's homes. This helped to ensure they had the knowledge to use equipment safely. Where a hoist was used to assist a person, staff confirmed they would never attempt to use this alone. Both care staff had to sign the records to confirm two staff had been involved in using the hoist. Staff were issued with torches to ensure they could always access each person's home safely. The service sought advice from occupational therapists to assess risks for people using the service. One person said; " They did a very thorough assessment of the house, as well as of us"

The service had safe recruitment procedures in place. Staff confirmed that they were not allowed to work alone until they had received full Disclosure and Barring Service DBS clearance, had shadowed an experienced member of staff until they felt confident and had been observed by management.

The service was regularly monitoring numbers of staff against numbers of people requesting care. The registered manager said that recruiting suitable staff had always been a challenge: "we're always doing recruitment…we'll never have enough staff". One strategy for keeping staffing numbers at an adequate level was by not taking on any new people if there were not enough staff to meet their needs. She said, "If we haven't got the availability, we don't take them on." There was also a pool of bank care staff available to fill in gaps on the schedule. The service had sufficient staff to keep people safe and meet their needs. People or their relatives confirmed that those who had been assessed as needing two staff for their care confirmed that they always had two care workers

People using the service confirmed that they were given a schedule each weekend of who would be visiting them the following week. They were satisfied with the time keeping of care staff and that staff were working for the allotted time. People confirmed they were notified if a care worker was going to be more than 15 minutes late. Members of the management team were on call 24/7 to cover any unexpected absences. They used a four-wheel drive vehicle in bad weather conditions to ensure staff can reach people in difficult locations.

Where people were supported with their medicines they were managed in a safe way. People received varying levels of support when taking their medicines, for example, from prompting through to administration. Medicine administration records (MARs) were written by the management team and arrangements were made with people and the local pharmacy to have people's medicines dispensed in a blister pack. The pharmacy organised people's medicines into separately sectioned blister packets, each marked with the day and time of day when different tablets should be taken. Staff had received medicine training and had competency assessments to ensure they were competent to carry out medicine administration. The management team checked medicine records each month to ensure they had been administered correctly.

People were protected from infection by suitable arrangements for disposing of waste. The service was using yellow bags for disposal of clinical waste such as soiled pads and where the council had withdrawn this service, they were double wrapping soiled items to reduce the risk of contamination before placing in the refuse bin.

Requires Improvement

Is the service effective?

Our findings

People gave their consent for day-to-day personal care by signing a consent form as part of the care planning process. If they did not want something done, such as a bath or shower, they were able to decline that aspect of the care

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. Whilst we found no evidence of anyone being restricted in any way, neither did we find evidence of an MCA assessment process in place and no records of any best interest decisions having been made. The registered manager was aware of those people who had given Lasting Power of Attorney to someone else and of the two different types.

On day one of the inspection, the service recognised that training on the Mental Capacity Act 2005 (MCA) had been insufficient to help all staff understand their responsibilities in relation to consent for people who lacked capacity. Some staff understood what lacking mental capacity meant but others did not.By the second day of inspection, a new training workshop had been designed to cover these issues with a mandatory target for completion by all staff of 12 months. We were also told that a new MCA Assessment form will be used on a trial basis for a three month period, actioned to start immediately.

We recommend that the provider reviews the requirements of the Mental Capacity Act 2005 to make sure best interests decisions are being carried out and recorded appropriately.

All staff who were interviewed confirmed that they had been given an induction and had shadowed experienced staff until they felt confident to work independently. The management team said they made individual decisions about how soon new staff were deemed competent to work independently. This varied according to previous experience, qualifications and an individual's confidence, so it lasted from a couple of weeks to several months. One member of staff confirmed this and said, "I wouldn't have gone out if I didn't feel confident on my own." Another staff member said of her induction period, "it was a really, really good experience for me." Part of the induction included reading a detailed collection of Best Practice Guidelines written by the organisation.

The service employed an independent qualified trainer/assessor who delivered a rolling programme of mandatory training, as well as additional optional training courses. The mandatory training programme included the following topics: Safeguarding Vulnerable Adults, manual handling, medication, basic first aid, infection control, nutrition and hydration, dementia and mental health awareness. A colour-coded spread sheet was seen which gave dates when staff had received training and when they were due for refresher training in the above subjects. The external trainer organised a rolling programme of workshops in the mandatory subjects so that people working shifts could attend.

The service was using the Care Certificate workbooks, produced by Skills for Care, for staff who were new to care as an occupation. All new members of staff were required to have their work observed and the booklet on "care practice" was completed. Care practice was then monitored at regular intervals using a checklist form. This meant areas for further development were identified by supervising staff.

Two of the three managers were qualified manual handling trainers and assessors. They undertook the practical manual handling training in the community. The assistant manager taught staff how to use people's individual equipment in their home. They recorded this in the notebook which was kept with each piece of equipment in each person's home, but there was no formal system to say all staff had been taught on all people's equipment. This meant that some members of staff might not have received training in all the different types of manual handling equipment.

Staff said they felt well supported by the registered manager, assistant managers and senior carers. They confirmed they received regular informal supervision and support from members of the management team. They said they were able to drop in to the office whenever they needed support and meet on a one to one basis on request. One member of staff described the supervision process thus: "(name) asked me how I was feeling about the job, we talked about some clients and she gave me feedback."

The registered manager said that she met regularly with staff and supervised and observed them when delivering care in people's homes. A care practice supervision form was used. There were some gaps of signatures and/or dates on some of the forms. Staff confirmed that the registered manager and assistant managers regularly worked alongside staff delivering personal care to observe their practice and provide support. One person said, "(name) was brilliant, anything I needed help with, she was there for me." Another person said, "I can't really fault the managers… They are always willing to help and their standards are high." A third person said, "we've got great support. (Name) is always at the end of the phone and they come straight out if we need help." Annual appraisals had been completed for 10 out of 17 with plans in place to complete the rest.
Staff received ongoing supervision and appraisals in order for them to feel supported in their roles and to identify any future professional development opportunities.

People were supported to have sufficient to eat and drink by staff either by prompting and monitoring people's intake of food or by actively preparing food for them, depending on the care plan assessment.

The service had active relationships with local GP surgeries and community nursing services. The registered manager liaised frequently with other professionals in order to help people access healthcare services and receive ongoing healthcare support. Healthcare professionals confirmed that the service delivers good care. One health professional said "They are fantastic with skin care… they have kept (name) healthy because of the care and attention they put in."

Good

Is the service caring?

Our findings

People using the service and their relatives made positive comments about the quality of the care provided and about the approach of the staff. Comments included the following: "I am completely satisfied with the help and care I receive"; "They were good and kind to us"; "Our experience has been very good."; "We are perfectly happy with them" "The service is excellent" and "We are highly satisfied with the service we receive."

People using the service and their relatives confirmed that support was usually provided by individual members of care staff, who knew them well. People said they had been able to develop good relationships with care staff. One person said, "There is often a lot of laughter and chat."

People said new staff were always introduced to them and initially visited with a known and more experienced member of the care team. "Wherever possible, Harcombe Valley ensure the same carer visits each time. We never get someone we don't know."

People were encouraged to express their views informally and directly with either the registered manager or one of the assistant managers. Care plans demonstrated that people had been actively involved in discussing possible options for their care, treatment or support. People we spoke to confirmed that they felt actively involved in planning their own care.

We asked people and their relatives if staff respected people's privacy and dignity; everyone said they did. The registered manager explained that they occasionally had requests from people using the service not to send staff wearing uniform. This was because they did not wish their neighbours to know they were receiving a service from an agency. The registered manager explained that in those circumstances they would always respect the wishes of the person and utilise aprons once within the house instead of uniform. They said, "That's their choice." Staff understood the importance of respecting people's dignity, privacy and independence. They were able to give examples of how they would promote a person's dignity, such as by using protective covers when doing personal care.

Confidentiality of people using the service was respected. For example, the registered manager explained that they never put the name of people in the same place as the number of the key safe code for that person's property. The weekly memo issued to care staff which gave information about the service being delivered to people was returned by care staff to the office for shredding.

Good

Is the service responsive?

Our findings

The service had a formal system for people to use if they wanted to raise a concern or a complaint. Information about this was contained in the Harcombe Valley Service User Guide. 92% of questionnaire respondents said they were happy that complaints or concerns had been well dealt with by the service. We heard from people who had raised issues informally. One of those had not been happy with the response, particularly the lack of an apology. One person said, "They should say something (when something goes wrong) they never say sorry." Nobody had ever raised a formal written complaint. Other people had been satisfied with the informal approach. One person said, "In our view it was dealt with satisfactorily." Another person said "They dealt with it in a reassuring way". Two relatives who were sent questionnaires also expressed confidence in the complaints process. We have asked the provider whether they kept records and analysed informal complaints to identify any trends.

We looked at the way the service assessed and planned for people's needs. Initial assessments were undertaken by the registered manager before the service started, with information entered onto a comprehensive form. This enabled the registered manager to talk to people and their families about the service they wanted and to identify their care and support needs. Additional information was also obtained from other health and social care professionals if appropriate. People using the service and their relatives confirmed they had been involved in the initial assessment process and that information from this was used to create their care plan.

Care plans contained information about the care and support people required during each visit. This included the personal care required; skin care; moving and handling requirements, use of equipment, food and nutritional needs and preferences and any support required with medication. Care plans were regularly reviewed with people to ensure they were receiving care which was still appropriate for their needs.

Relatives and friends of people using the service were positive in their comments. One person said "they've been very flexible about how we choose to use our hours."

Care staff confirmed that they called each other to inform them if they were running late or needed extra equipment. One of them would then call the office to ask them to inform person awaiting a service. This meant that staff were being responsive to the needs of people using the service and were doing all they could to allay anxiety and prevent missed visits. The registered manager explained that she was proactive in ensuring people using the service got what they needed in a timely manner. For example, she described going directly to one person's GP to collect their prescription, rather than wait for it to be sent electronically to a local chemist, as she had discovered this was a faster and more efficient system. This meant that people using the service were getting more responsive care.

A staff member who had been first on the scene after an accident in a person's home was praised by their family for their prompt emergency action.

People confirmed that the registered manager was very responsive and visited whenever there were issues. One person said, "If there's ever an emergency, [name] will come out right away." Another person said, "In the event of unexpected difficulty they are contactable at weekends and at unsociable hours and able to provide help."

Good

Is the service well-led?

Our findings

This was a small family run business, which has operated for over 20 years. The management team consisted of the registered manager and her two daughters. Each had a clearly defined role. The team communicated readily with each other on a daily basis. They were supported for the last 15 years by the services of an independent consultant/trainer who organised and delivered training and staff development, and also assisted with policy reviews and best practice guidelines. This represented a valuable addition to the family team, as an external observer was able to take an impartial view.

For example, the consultant undertook some of the auditing procedures. Similarly, the organisation employed an independent employment law firm for advice and guidance on employment issues.

The provider had last used a questionnaire to ascertain the views of people using the service in August 2015. They did not find it had yielded much useful information, so at the time of the inspection they were considering new ways to gain feedback. In order to make quality assurance systems more robust, the organisation was also considering different ways to gather anonymous feedback from people using the service. This showed that they were committed to gaining meaningful feedback in order to improve their service.

The registered manager was not initially fully aware of their responsibilities in relation to making the various required notifications to CQC and safeguarding alerts to the local authority team. Guidance for providers was sent to the registered manager after the first day of inspection. An immediate notification was made of a serious injury which had taken place 11 days before the inspection. By the time of the second day of the inspection, the management team had undertaken a thorough investigation of the incident. The organisation immediately responded by notifying their care staff of the learning from the incident in order to raise awareness and took steps to avoid anything similar happening in future.

The culture of the organisation was one of strong leadership combined with informality and approachability. People using the service, as well as those working for the organisation, were encouraged to discuss issues as they came up, rather than wait or use more formal systems. Values of the management team included honesty, focusing on the needs of each client as paramount and continuously striving for improvement. The registered manager said, "I am most proud of the quality of care we give and our good reputation."

There were numerous examples of changes being made to improve delivery. For example, a new form to document competence assessments in moving and handling and a new system to ensure supervision was more structured and frequent were created in 2016. Care plans have moved from being two paper copies, to being created and held electronically in the office, with one paper copy left in the person's home.

People using the service, staff members and other professionals confirmed the philosophy of client centred care. One said, "There is an absolute passion to do the right thing for the service user, the individual." Another comment made was, "They know about everyone's personal quirks. They really go above and

beyond."

The provider had various quality assurance systems in place to help them have a clear idea of the quality of the service they delivered. Systems included regular audits of medicines administration records (MAR) sheets, care plans, communication books and monitoring of accident and incident records. The organisation used information gained from audits to improve their service. For example, audits of care plans resulted in the finding that some staff were reluctant to change the plan when a person's needs changed. This was discussed with staff to explain the importance of having an accurate up to date record and improvements were monitored. 'Spot' checks were also carried out on a random basis, with a checklist being completed. These enabled the management team to ensure care staff were arriving on time and supporting people appropriately. A member of the management team said, "We look at all accidents and incidents and ask ourselves, 'Could we have done anything different?."

People using the service, health and social care professionals and staff all confirmed that the service had a good reputation locally. Professionals from other agencies described good working relationships and praised the organisation for good communication with them. One person said, "(Harcombe Valley) are very good at notifying us if there are any problems."