Highland Care UK Limited

Highland Care UK Limited

Inspection report

2a Heigham Road
East Ham, Newham
London
E6 2JG

Tel: 02034890790
Website: www.highlandcaresuk.co.uk

Date of inspection visit:
25 May 2017
01 June 2017

Date of publication:
29 September 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

Highland Care UK Limited provides personal care for people in their own homes, some of whom may be living with dementia. We inspected the service on 25 May and 1 June 2017 and at the time of this inspection 20 people were using the service. This was the first inspection of this service since it became registered.

There was a registered manager at 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.

The provider had systems in place to ensure visits to people who used the service were not missed. Safe recruitment checks were carried out. The service had safeguarding and whistleblowing policies in place and staff knew what action to take if they suspected someone was being abused.

People had risk assessments in place to ensure safe care was provided and potential risks were minimised. There were arrangements in place for the administration of medicines. However, we have made a recommendation around the safe management of medicines.

People felt that they were supported by skilled and experienced care staff. The provider supported staff with regular training opportunities, supervisions and appraisals. The provider was aware of their responsibilities around the Mental Capacity Act 2005. Staff demonstrated awareness of needing to obtain people's consent before delivering care. People were supported with their nutritional needs and were supported to access healthcare when required.

Staff were aware of people's needs and preferences. People thought staff were caring. Staff demonstrated their knowledge of The Equality Act 2010 and delivering care in a non-discriminatory way. Staff demonstrated their awareness of how to provide dignified care, and encourage people's independence.

Care plans were personalised and staff demonstrated awareness of providing personalised care. Complaints were dealt with appropriately and in accordance with the provider's policy. The provider also kept records of compliments about the service.

People and staff spoke positively about the management team. The provider had several systems in place to obtain feedback from people who used the service. Staff had regular meetings to stay up to date with service development. The provider had various systems in place to check the quality of service provided.

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. The service had a system in place to ensure visits were not missed. Relevant recruitment checks were carried out for new staff including criminal record checks which were up to date.

Staff were knowledgeable about safeguarding and whistleblowing procedures. People had risk assessments in place to ensure risks were minimised and managed. There were arrangements in place for the administration of medicines.

Is the service effective?

Good

The service was effective. People felt staff had the skills needed to provide care. Staff were supported through training, supervisions and appraisals.

The provider was aware of what was required of them to work within the legal framework of the Mental Capacity Act 2005. Staff were aware they needed to obtain consent from people before giving care.

The service assisted people to liaise with healthcare professionals as needed. Staff were aware of people's nutritional needs.

Is the service caring?

Good

The service was caring. People thought staff were caring. Staff demonstrated a good understanding of people's needs and care preferences.

Staff received training and were knowledgeable about equality and diversity issues. The provider had a policy and gave training to staff about respecting people's privacy and dignity. Staff were knowledgeable about respecting people's privacy and dignity and encouraging people to maintain their independence.

Is the service responsive?

Good

The service was responsive. The service was responsive. Care plans were comprehensive and were written in a personalised way. Staff knew how to deliver care in a personalised manner and were aware of people's preferences.

People knew how to raise concerns or make a complaint. The provider had a complaints policy and responded to complaints in accordance with this policy. The service kept a record of compliments received.

Is the service well-led?

Good

The service was well led and had a registered manager. People and staff spoke positively about the management team.

The provider had systems in place to obtain feedback from people including feedback surveys and telephone monitoring. The service had regular meetings for care staff.

The provider had various quality audit systems which included spot check observations of care staff at work.

Highland Care UK Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

'This inspection took place on 25 May and 1 June 2017. The provider was given fourteen hours notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. One inspector carried out this inspection.

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 evidence we already held about the service including notifications the provider had sent us about specific incidents, accidents, safeguarding concerns and deaths.

During the inspection we spoke to the provider and the registered manager. We reviewed four care records, four staff files and records relating to the management of the service including policies, medicines, staff training, complaints, compliments and quality assurance. After the inspection we spoke with two people who used the service, two relatives and two care staff.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe with care staff. One person told us, "I certainly do feel safe." A relative told us, "Yes, [person is] one hundred per cent safe." People and their relatives also confirmed staff had never missed a visit. The service had a system in place to deal with missed calls. Staff were required to log in and out of visits. The system showed if staff had not logged into the visit and office staff would call the allocated staff member to find out why. The provider explained that where staff were running late, they usually let office staff know so that the person waiting for the visit could be contacted. The service had two supervisors and a pool of staff including two drivers who could cover emergency staff absences. This meant there were processes in place to ensure people did not miss out on a visit.

The provider had a process in place for recruiting staff that ensured relevant checks were carried out before someone was employed. For example, we found staff had Disclosure and Barring Service (DBS) criminal record checks carried out to confirm they were suitable to work with people and these were up to date. We saw staff had produced proof of identification, confirmation of their legal entitlement to work in the UK and had been given written references. This meant the provider had safe recruitment checks in place to ensure suitable people were employed.

Staff were knowledgeable about recognising and reporting concerns of abuse. One staff member told us, "When something is going on, you can alert your manager or supervisor." Another staff member told us, "I would report to the manager or I could tell family members. Whistleblowing is I could tell the social worker, the GP or the CQC [Care Quality Commission]." The provider had comprehensive safeguarding and whistleblowing policies which gave guidance to staff on how to report concerns of abuse.

The provider had a financial protection policy which gave clear guidance to staff on how to handle people's money appropriately. At the time of this inspection, the service did not have the responsibility for managing anybody's money.

People had risk assessments documented in their care plans to assess the safety of delivering care in the person's home. Risk assessments included medicines, pressure sores, moving and handling, infection, isolation, suffocation and environmental risks in the person's home. Where risks were identified, further information about the risk was detailed and guidance for staff on how to minimise the risk was documented.

For example, one person had a risk assessment for moving and handling. The risk management plan stated, "Risk of fall and accident if [person] is not transferred using the right equipment and by two staff to always assist in transfers. Hospital bed must be lowered to the floor when left alone, bed guard must be raised up at all times to reduce risk of falls. Wheelchair must be positioned close to the bed before any transfer must be done." Records showed that two staff attended the visits when transfers were required.

The service had a medicines policy which gave clear guidance to care staff of their responsibilities regarding medicine administration. Appropriate arrangements were in place for the management of medicines. Staff had up to date training relating to medicine administration and records showed their competency was

evaluated before they were allowed to administer medicines unsupervised.

Care records showed where people managed their own medicines or where a family member provided this support. People and relatives we spoke with confirmed this was the case. However we found for one person the medicine administration chart (MAR) was not fully completed. The provider explained the gaps were due to the person not receiving a service on the days where there was no staff signature because they were visiting family or at the hospital. However this should have been recorded on the MAR chart to explain why there were gaps in administration. We recommend the provider follows good practice and guidance in managing medicines for people receiving social care in the community.

Good

Is the service effective?

Our findings

People and their relatives told us staff had the skills needed to provide them with care. One person told us, "They seem to [be skilled]. Yes I think so." A relative told us, "I have a lot of faith in the carers."

Staff confirmed they received regular training opportunities. Records showed that new staff completed training in the Care Certificate standards of care and shadowed experienced staff. The Care Certificate is an identified set of standards that health and social care workers are expected to adhere to in their daily working life. Records showed that staff were up to date with training including safeguarding adults, infection control, moving and handling and health and safety.

Records showed staff received support through supervisions. The provider's supervision procedure was for staff to have a quarterly face to face supervision. Topics discussed during supervision included training, timekeeping, record keeping and any concerns the staff member had about people who used the service. Staff also received an annual appraisal and records showed these were used to reflect on the staff member's performance during the last year and identify goals for the coming year.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application process for depriving a person of their liberty when they received a service in a community setting, like a domiciliary care agency, includes obtaining authorisation from the Court of Protection. The provider was knowledgeable about these procedures but at the time of this inspection, told us there was nobody using the service who was having their liberty deprived through the Court of Protection.

Staff were knowledgeable about obtaining consent from people before giving care. One staff member told us, "We greet [the person]. We tell them what we are going to do. If they agree to it then we carry on." Another staff member said, "We introduce ourselves and we use [the person's] care plan. At times they tell us what they need but not always. So we ask if it is okay that we do something. If they are okay with it then we do it."

People confirmed they consented to their care. Records showed they had signed their care plan and risk assessments to consent to the care they received. Care records also contained a 'consent to share information' form which people signed if they were happy for their information to be shared with other agencies as needed. We noted one person's care plan and risk assessments indicated the person consented to receiving care but was unable to sign for physical reasons.

Records showed staff received training in fluids and nutrition. Care records indicated if the person required support with meal preparation and eating. For example, one person's care plan stated, "Should always support with meals and preparation and meals kept within her reach at all times." Staff confirmed they assisted people to maintain their nutritional needs. People confirmed this was the case and they thought staff did a good job.

Care files showed referrals were made to healthcare professionals where appropriate For example we saw one person had a referral to the district nurses and other people had a referral to occupational therapists. This meant people were supported to access healthcare if this was required.

Good

Is the service caring?

Our findings

People told us they thought staff were caring. One person told us, "The woman I have now, she's very good." A relative told us, "Oh yes, treating people with respect, compassion and gentleness goes a long way. I would say the carers go above and beyond." Another relative said, "I'm happy with the care." People and relatives confirmed they were involved in their initial assessment before receiving care and in decision-making around their care plan.

Staff were knowledgeable about developing positive relationships with people. One staff member told us, "Getting to know the person. This happens gradually. You have to talk to [the person], find out their preferences and what are their choices." Another staff member said, "We make the relationship by talking to [the person]. Throughout as we care for them we get to know them more and the trust is built." This showed people who used the service could be confident that staff were willing to provide a caring service.

Training records showed staff had received training in equality and diversity. Staff described how they ensured they did not discriminate against people who used the service. For example, one staff member explained that some people for religious reasons liked care staff to wear shoe covers on their feet and staff respected this. The care plan confirmed this was the case. The same staff member also said, "They would not like us to enter their prayer room so we don't. We treat everybody equal. We try to work around who they are." Another staff member told us, "[Person's sexuality] is their choice. I'm not going to say something is wrong about their choice. I still support them."

Staff were knowledgeable about respecting people's privacy and dignity. One staff member said, "Ask family members to leave the room when we are giving personal care. Some people would prefer the door closed." Another staff member told us, "We close the door and draw the curtains before we give care."

Records showed that staff had received training in respecting people's privacy and dignity. The provider had a policy on dignity, privacy and respect which reminded staff that they were guests of people who used the service and they should behave accordingly. The policy also gave guidance to staff in line with the Equality Act 2010 about not discriminating against people who used the service regardless of age, gender, disability, race, religion or belief, gender reassignment, sexual orientation, marriage or civil partnership, and being pregnant or on maternity leave. The above showed people could be confident that staff would respect them and provide a non-discriminatory service.

Staff were knowledgeable about assisting people who used the service to maintain their independence. One staff member told us, "We try to encourage them to do as much as they can for themselves and not do it for them. If they can't do it, then we will do it." Another staff member said, "Some of them can do some things for themselves so we allow them to do it."

Good

Is the service responsive?

Our findings

Staff understood how to deliver personalised care and were knowledgeable about people's preferences. One staff member said, "The care that we provide for each individual is about them, what they prefer and the way that they like things. For the majority of people we have enough time to give personalised care." Another staff member told us, "I like [the person] to tell us how they want their care. If the person wants things done in a particular way, you do it in their way. At times it takes a lot of your time but we try to do it the way they want it." Staff confirmed that people had care plans in their homes which they referred to for details of the support needed.

People had an initial assessment before receiving care to ensure the service could meet their needs. Care records were detailed and personalised containing the person's wishes and preferences. Clear instructions were documented for when and how specific care tasks were to be completed. Care plans stated when family members attended to meals or medicines. However, detailed instructions were documented on how to complete these tasks so that staff could assist if needed. Person centred support plans gave details of the person's history, what is working well in person's life, the person's main difficulties and concerns and the outcomes the person wanted to achieve through their care package. Records showed that people's care records were reviewed regularly and people and relatives confirmed this was the case.

People told us that they knew how to complain if they were not happy with their care. People and a relative also confirmed they had made a complaint and were happy with the resolution. One person said they had complained, "Only when they first started but not had to since then."

The provider had a comprehensive complaints and compliments policy. Records showed that eight complaints were made in the last year and were dealt with and resolved the same day they were received to people's satisfaction. The provider told us if they received complaints about staff arriving late for visits, they checked with the staff member in case it was the previous visit that caused the delay and then would resolve any issues. The provider also said they followed up with the complainant to check the issue is resolved.

The service also kept a record of compliments made. For example one relative had written, "Special thanks to [staff member] who was her main carer and was very kind and supportive." Another example was a relative wrote a letter which stated, "We just wanted to thank you all for the kindness and friendship shown to [person using the service]. All your girls showed professionalism and compassion we have not seen before in any care package." A third relative wrote, "Thank you for all the care and attention given to [person who used the service]."

Good

Is the service well-led?

Our findings

The service had a registered manager. People told us they thought the service was well managed. Relatives told us they felt able to approach the registered manager and other staff based at the office. One relative explained the service was proactive in communicating with them and informing them when there were concerns. Staff told us they felt supported by the management team. One staff member said, "Yes I do [feel supported]." Another staff member told us, "Yes they are very supportive." This meant the provider promoted an open and transparent and open culture.

The provider had systems in place to obtain feedback from people using the service in order to improve the service. People who used the service and relatives confirmed they were regularly asked for feedback and their comments were acted upon. Records showed that in the annual feedback survey in 2016, people indicated that they were satisfied overall with the service they received. The provider also contacted people who used the service by telephone at least annually to find out if they were happy with the service. For example, one person fed back on 8 March 2017 that they were happy with their regular carers and said, "If carers are changed then it would be an issue."

The provider held regular meetings for office staff. Records for the meetings held on 16 January 2017 and 1 March 2017 showed topics discussed included phone calls, office cleaning, complaints, compliments, care assessments, risk assessments, recruitment and audits. Care staff meetings were held every three to four months. Records for the meetings held on 9 October 2016 and 15 January 2017 showed topics discussed included changes in people's needs, the medicine policy, timekeeping and attendance, uniform, duty of care, confidentiality and equipment and safety. This meant staff could be updated on provider or policy changes.

The provider had several quality assurance systems in place. The provider told us the quality assurance systems helped to identify concerns and to improve the service provided. For example, the management team carried out regular review and quality checks through visits to people who used the service. The visit included a spot check observation of staff carrying out their care tasks. The 'Review and Quality Check' form covered checking the information kept at the person's home including health needs, daily living needs and risk assessments. People using the service were asked for feedback at these visits about the quality of the service and to indicate if they wanted a reassessment. For example one person indicated on 10 March 2017, "I have a satisfactory relationship with my carer. She keeps to time."

Quality checks included log book audits which were done on log books that were returned to the office when full. These identified any issues and were signed by the staff member who did the audit. For example, the audit of a logbook on 22 April 2017 noted there was no surname or address of SU and the staff signature was missing for 12 April 2017. Another example for a logbook audit done on 07 April 2017 noted there was no name or address and the book had been finished and carried on to two extra separate pages rather than starting a new book. The provider told us when issues were identified the relevant staff member was invited to the office to discuss this and records showed this was the case.