Cheshire West and Chester Council

Cheshire County Council Domiciliary Care

Inspection report

4 Civic Way
Ground Floor
Ellesmere Port
Cheshire
CH65 0BE

Tel: 03001237742
Website: www.cheshirewestandchester.gov.uk

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20 June 2018
22 June 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an inspection of Cheshire County Council domiciliary care on the 18, 20 and 22 June 2018. All visits were announced.

This was the first inspection of this service since it was registered in July 2016.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to predominantly older adults. The service operates a reablement service to people following discharge from hospital for them to gain independence in daily living skills once more. Support packages typically last 6 weeks. The service covers all of the Cheshire West area. At the time of our visit, the service supported approximately 100 people.
A registered manager was in post. 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.

Staff had a good understanding of the types of abuse that could occur and how to raise concerns. Staff were aware of the whistleblowing procedure and how external agencies could be contacted to raise theses.

Recruitment was robust and included checks to ensure that new staff were suitable to support vulnerable people.

Medicines management was robust with any error in medication recording being picked up quickly, managed and reported appropriately.

Staff rotas were in place and systems established to ensure that sufficient staff were available to meet people's needs. Staff rotas meant that calls were never missed and that both staff and people who used the service were kept safe.

Risk assessments were in place. These were up to date and minimised potential risks in the support they received as well as risks in their home environment.

The registered provider paid attention to the infection control with details for staff available promoting this as well as the provision of personal protective equipment to minimise infection spreading.

Staff received the training they needed to perform their role. Staff received supervision so that their performance could be discussed and developed.

The nutritional needs of people were taken into account with support being provided that sought to

increase and maintain people's independence.

The health needs of people were taken into account with people's health being monitored and responded to where appropriate.

The registered provider had set up effective communication systems within the service to ensure that staff were aware of the progress of individuals as well as changes to positive working practices.

People were treated in a kind, patient and dignified manner.

Staff were aware of how people's privacy could be promoted.

People's personal information was kept safe and secure.

The ethos of the agency was to promote independence and for people who used the service to regain life skills to achieve full independence. Care plans were devised in such a way to achieve this and people felt as though they had regained essential life skills in order to live independently.

Information was provided to people in appropriate formats with alternative formats being made available.

Care plans were person centred and geared to achieving independence for people. Appropriate assessments on people's needs were gained prior to them using the service. Assessments covered all aspects of people's daily living.

The service did not directly provide assistance with social activities yet the support provided enabled people to re-stablish social links once independent living had been achieved.

A complaints procedure was in Place. No one had needed to make a complaint yet information was available if the need arose.

The service had a registered manager in place. Staff felt supported by the management team.

People who used the service considered that it was well run.

A number of effective audits were in place to measure the quality of the support provided. Medicines audits had picked up the need for further training and support in the administering and recording of medication.

People were asked for their views of the quality of the service through questionnaires and surveys which were reviewed regularly.

The registered provider always informed CQC of any adverse incidents that affected the well being of those who used the service.

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.

Sufficient staff were available to support people who used the service.

Staff were recruited appropriately.

Risk assessments were in place to ensure that people were kept safe.

Is the service effective?

Good

The service was effective.

Staff received the training and supervision they needed to perform their role.

The nutritional needs of people were met.

People told us that they considered staff to be experienced and well trained to support them.

Is the service caring?

Good

The service was caring.

People told us that the staff were caring.

Staff promoted the independence of people to regain daily life skills.

People's confidential information was protected.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred.

Assessments were obtained outlining people's needs.

A complaints procedure was available for people to raise concerns.

Is the service well-led?

Good

The service was well led.

The registered provider used a variety of audits to check on the quality of support provided.

The registered provider always informed us of adverse incidents that affected people who used the service.

People told us that the service was well run.

Cheshire County Council Domiciliary Care

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 the 18, 20 and 22 June and was announced. We gave the service 48 hours' notice of the inspection visit because we needed to be sure that the registered manager was available given that this was the service's first inspection.

Inspection site visit activity started on 18 June 2018 and ended on 22 June 2018. It included contacting people who used the service by telephone in order to gain their experiences and this was done on the 20 June. The other dates involved visiting the office location to see the registered manager, talk to the staff team, to review care records and policies and procedures.

The inspection team consisted of one Adult Social Care Inspector and an Expert by Experience. An expert-by-experience is a person who has experience of caring for someone who uses this type of care service. The expert-by-experience spoke to people who used the service to gain their views.

Before our visit, we reviewed all the information we had in relation to the service. This included notifications, comments, concerns and safeguarding information. Our visit involved looking at 10 care plans, training records, policies and procedures, medication systems and various audits relating to the quality of the service. In addition to this we spoke to 11 people who used the service. We also spoke to the registered manager, two care co-ordinators and four care staff. We contacted other professionals who had regular contact with the service to gain their views.

As part of our inspection, we ask registered providers 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. A PIR was returned to us when we asked.

Good

Is the service safe?

Our findings

People told us that they felt at ease with the staff team and had established good relationships with them. They told us, "I was very happy with the support. The carers were very punctual, very attentive, helpful, pleasant and friendly. They couldn't do enough for me," "The carers watch me take my medications and then write it in the book" and "Carers were always punctual."

We looked at how medicines were managed. Care outlined whether support by staff was needed to assist people with their medication. Care plans indicated that not everyone needed support but outlined how medication when prescribed was taken; for example by the person themselves or by a family member. Where staff offered support; clear instructions were in place for staff to follow in order for people to receive their medications when required. Instructions were always in place as to where medication was stored and could be accessed.

Medication administration records were available for each month. The records had been completed appropriately and included the route of administration, the medication itself, dosage and other considerations that staff needed to make, for example if medications were time-critical.

Records were audited by the registered manager and there had been instances were errors had occurred. These ranged from records not being signed to medication being missed on occasions. These had been picked up by medication audits. Action had been taken in response to these. Medical advice had been sought, errors had been reported to us and as low-level safeguarding alerts and further training offered to the staff team. Staff performance with medications, where applicable, was closely monitored with a clear plan of performance management in place. People told us that they received support with medication from staff appropriately.

The recruitment process was found to be robust. Information in recruitment files of people who had come to work at the service since the service was registered in July 2016 was looked at. Information included an application form, interview notes and references. Further checks included a Disclosure and Barring Service check (known as a DBS) and these confirmed that people had not received any past convictions that would mean they were not suitable to support people who used the service. Members of staff had recently undergone the recruitment process and considered it to be fair and thorough. Information was also available confirming the identity of each member of staff.

Staff rotas were available. These were placed on a real time computerised system. When staff arrived at someone's home; they used a mobile phone to scan a disc discreetly positioned on a person's care plan. This confirmed the time they had arrived, left and whether the call had been made. This enabled senior staff to ensure the safety of each staff member and that the call had been undertaken. This also enabled the needs of people to be matched with staff numbers and their deployment. People told us that staff always turned up and that there was consistency in the staff team who supported them.

Risk assessments were available. These covered the specific hazards people may face while they were being

supported or hazards within their individual homes that needed to be taken into consideration. Typical risk assessments related to manual handling where applicable. Risk assessments were in place as soon as the support package commenced. There was evidence that where applicable, some risk assessments had been reviewed. Where hazards were present, additional information was available on how to keep people safe during the support they received. There was evidence also that people had signed their risk assessments confirming their agreement with them. Risk assessments in relation to the environment where support was to be given were also updated.

Staff were clear about the types of abuse that could occur and knew how to report such concerns. They were confident that the management team would refer any issues to the local authority safeguarding team so that any allegations could be investigated and appropriate action taken. The confirmed that they had received training in this as part of their ongoing training and for one person as part of the induction process. Our records indicated that we were always informed of any safeguarding incidents. These had related to medication errors and these had been referred as low-level safeguarding concerns. Low level safeguarding incidents are those that do not meet the threshold for a formal investigation.

Staff were aware of the whistleblowing process. They told us that if they had any concerns, they could raise this internally with the registered provider or refer to external agencies such as CQC. A procedure was in place for staff to raise any care concerns. No whistleblowing concerns had been received by us since the service was registered in July 2016.

Care plans outlined the consideration staff needed to make in respect of infection control. This included the use of personal protective equipment (PPE) such as gloves and disposable aprons. All staff had received infection control training.

Accidents and incidents were recorded. These were entered onto a database to enable the registered provider to analyse any patterns or trends. The number of such events had not been sufficient enough to enable a trend to be identified.

Good

Is the service effective?

Our findings

People commented on the skills and knowledge of staff. They told us, "They absolutely have the right skills and experience," "They are very well trained, they have had a lot of experience in caring for people" and "they always attended to their work and carefully considered all aspects of my support".

Staff confirmed that they had received training and felt that it had assisted them in their role. A computerised training matrix was in place. This outlined training received such as mandatory health and safety topics, for example, first aid and infection control as well as training in safeguarding, equality and diversity and medication. The training matrix was presented through a colour coded system which alerted the registered manager in advance any refresher training that needed to be done. We witnessed an administrator with the service organising training with individual staff members in data protection for the near future.

A structured induction process was in place. This involved staff receiving training and if staff were new to the care profession, the induction involved the care certificate. The induction met the requirements of The Care Certificate which is a nationally recognised qualification based on a minimum set of standards, that social care and health workers follow in their daily working life. The standards give staff a good basis from which they can further develop their knowledge and skills. All staff undertook a period of shadowing an experienced member of staff before they worked with people independently. One member of staff had been recruited by the service within the months prior to our visit and confirmed that this process had helped them to settle into their new role.

Staff confirmed that they received supervision in a number of ways. This included one to one meeting with their line manager as well as regular staff meetings. We attended one staff meeting and saw that it was an opportunity for staff to meet up and for information to be passed onto them from their line manager. Other supervision was in place specifically if a performance issue had arisen. This had been the case with some medication management where medicine recording issues had occurred. This demonstrated that staff were invited to express if they needed any further training or support in medicines management.

A system of annual appraisals was in place for staff who had worked at the service for some time. These enabled staff to identify their strengths in their work as well as any areas of development.

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 the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. In the community any restrictions need to be referred to the Court of Protection (CoP) for authorisation through the local authority. At the time of the inspection there was no one who required a CoP referral to the local authority.

The registered manager and other senior staff had all undertaken training on the Mental Capacity Act. Staff we spoke with demonstrated a working understanding of this.

The nutritional needs of people were recorded in care plans. This included any dietary needs that people had. Care plans for some people outlined the practical support that people may need in preparing meals. The emphasis was on enabling people to regain skills in preparing meals or drinks and detailed levels of support were available for staff to adhere to. No one commented specifically on the support they got if they required help with preparing meals but were complimentary about the general support they received from the care staff. All staff had received training in food hygiene.

We looked at how communication worked within the agency. All staff had been provided with a mobile phone which meant that they could contact their line manager or be contacted if they had a query or needed assistance. In addition to this, a computerised system for logging in enabled line manager to ensure staff had safely arrived at addresses and that calls had not been missed. Staff meetings provided a forum for communication.

Any health needs of people were outlined within care plans and assessments. There had been occasions where staff had arrived at a person's home and found them to be unwell. In those instances, staff took steps to advise health professionals such as doctors being called to ensure that people's health needs were met.

Good

Is the service caring?

Our findings

All people we spoke with were positive about the caring approach of care staff. They told us, "The personal care from staff exceeded my expectations," "They always asked what I needed and how I was," "I was never rushed" and "There was a great rapport between me and them." People felt that staff were considerate yet were mindful that the staff sought to encourage people to become as independent as possible in their daily lives.

The main purpose of the service was to re-enable people to gain independence in their daily lives following a hospital stay. The support typically lasted for a period of six weeks. This aim was reflected in care planning which sought to identify the main obstacles to people becoming fully independent and focussing on those areas where people could help themselves. As time progressed, care plans were altered to reflect progress made. People told us that their independence had been restored and considered by the service. They said, "They [Staff] did everything they could, enabling me to be independent," "In the morning the carers give me a body wash but they ask me to help where I can" and "The carers helped me to be independent again."

As a result of the aims of the agency to re-able people to gain everyday life skills, there was an expectation that people would be involved in this process. This was reflected in how care plans were written and how reviews documented progress made in each area. The level of involvement was confirmed through people agreeing their plan for reablement.

Staff gave us an account of how they promoted the privacy of people. They told us that closing doors and curtains when assisting in personal care was their priority. They also told us that they were mindful that when they entered people's homes, they needed to be respectful of this.

Sensitive information was kept secure at all times. There were stringent checks before people could gain entry into the main office through the use of coded doors and the issuing of identity passes. In turn all personal documents were stored in lockable cabinets so that people's details could be protected. This also related to personal staff records.

The communication needs of people were taken into account. Assessment and care plan information outlined any limitations people had with vision or hearing and attention was paid to whether people wore glasses or had hearing aids, for example. While people were able to verbally communicate their needs, provision was included in assessments for people whose first language was not English.

Information was provided to people about the aims of the service and what they should expect during their care package. This was provided to all people and contained relevant information about the agency, the skills and training received by staff and the contact details of people. These were all routinely placed within care plans. Alternative formats were available to those with specific communication needs.

Good

Is the service responsive?

Our findings

People told us that they had never needed to make a complaint about the standard of support provided. People were aware of the complaints procedure and how this would assist them to raise any concerns. People were aware of their care plan and were involved in influencing the aims of their care plan which were personal to their individual goals.

Assessments were obtained before a service was offered to people. Assessments included information from the local authority or hospital outlining the medical, social and daily lives of people with the aim of them regaining full independence in their daily lives. Once received; an assessment was then made by senior staff within the service as to whether a care package could successfully be provided to the individual. Assessments were then translated into care plans.

Care plans were person centred providing staff with an indication of the specific support people needed in order to regain life skills. This included, for example, people regaining confidence with their mobility or being able to prepare meals on their own. Care plans offered specific aims that were individual to that person. Care plans outlined personal preferences and like/dislikes people had. Consideration was also made to the social interests of people and how successful support would enable them to lead independent lives once more.

All care plans showed a positive progression for people in achieving independence. Care plans were regularly reviewed to assess how people had progressed. Care plans demonstrated how the aims people had achieved during the time of their care package. As people made progress; care plans were amended to reflect this. Care packages were provided over a six-week period typically. Where extra support was needed after this time; the service sought to facilitate this with other agencies; for example.

People were aware of their care plans. There was evidence within care plans that people had been involved in these and had signed to confirm their agreement with the way they were to be supported.

Daily records accompanied care plans. These provided detailed accounts of how staff had supported people in assisting them with their aims set out in their care plans. Where progress had been made in achieving elements of care plans, these were clearly recorded.

Reference was made in care plans to people's interests and their social history. No care plan we looked at saw the staff team supporting people to attend activities as the support provided was to assist people to regain skills in everyday household and personal care tasks following a short stay in hospital. The personal aspirations of people were recorded in care plans outlining their wish to return to leading an independent life including interests and activities they wished to pursue. As a result, the work done by the agency sought to facilitate the social interests of people for a later date.

Technology was used through computerised staff rotas. A scanner was available on each care plan for staff to use to confirm they had arrived at each call. These were discreet and did not impact on the privacy of

individuals as they were contained within a secure computerised system. Staff had easy access to these and systems were designed to ensure that calls were met, support could be provided and that staff were safe.

The service had a complaints procedure in place. This was made available to all people who used the service within their care plan. This outlined how the service would respond to concerns or complaints and the timescales involved for responding to them. No complaints had been received by the service. According to our records, we had not received any complaints about the service.

Good

Is the service well-led?

Our findings

People were complimentary about the running of the agency and the support they had received. They said, "The manager and colleagues have a structured systems and work to it. They were considerate and I would wholeheartedly recommend them," "The agency is well led, I have never heard a bad word against them" and "I feel that it is well led. They put my mind at ease." Another person told us, "They are top notch, they really are up to the job."

There was a registered manager in post at the time of the inspection. The registered manager had been in post since July 2016 and was aware of their regulatory responsibilities. The registered manager was aware of the individual needs of people and was present during our visit.

Staff told us that they considered the service to be well run and they had received support from the management team. They felt the registered manager was approachable. Staff meetings took place regularly. We attended one such meeting to gain the views of one staff team. They confirmed that they received regular contact with their line managers and staff meetings were used to share information and to update the staff team of issues that affected their work.

The registered provider had established a system of spot-checks. Staff members had their performance and the approach they used with people who used the service monitored. This ensured that staff supported people in a positive manner in lines with the ethos of the service. We saw documents confirming that staff had received such checks and staff confirmed they had taken place. Checks were detailed and covered not just the manner in which people were supported but adherence to policies and procedures. Included was how staff utilised equipment provided to them as part of their role and how they presented themselves as representatives of the service. All spot-checks were audited by the registered manager to ensure that the quality of support was being maintained.

Other audits were in place. The registered manager had an overview of training received by staff. This followed a "traffic light" system indicating when refresher training was due. We witnessed training being arranged by the service's administrator.

Other audits related to medication administration. It had been identified by the service that some medication errors had occurred. These had not had a serious impact on people yet audits had effectively identified issues. The registered manager had identified these through audits and reported them as low-level safeguarding concerns to the local authority and had let us know as notifiable incidents. Where these had occurred, staff had been retrained and received the support required to ensure that administration was safe. An option was available to the registered manager to identify those staff who needed further support or needed their performance to managed more formally through procedures.

The registered provider always informed us of any incidents that adversely affected the well-being of people they supported.

The views of people who used the service were regularly gained. A survey was sent out to people at the end of their period of support. All returned surveys were audited by the registered manager to address any comments that may have arisen. We looked at completed surveys and found that they contained positive comments about the support people had received.

The re-ablement nature of the service meant that close partnership working was required with other agencies such as, for example, social workers and district nurses. This involved daily contact with other agencies in order to co-ordinate care packages for people and this worked well.