Graceful Care Ltd

Graceful Care

Inspection report

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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

About the service
Graceful Care is a domiciliary care agency providing personal care and support to people living in their own homes. The agency offered care to younger and older adults. At the time of our inspection 236 people were using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People were supported to take their prescribed medicines safely. We have made a recommendation about training for staff on medicines support.

The provider had systems in place to safeguard people from the risk of abuse and staff knew how to respond to possible safeguarding concerns. The provider followed safe recruitment procedures were to make sure new staff were suitable to care for people. Staff followed appropriate
infection prevention and control practices.

Staff were supported to provide effective care through induction, training, supervision and observations. The provider assessed people's needs to ensure these could be met. People were supported to maintain health and access healthcare services appropriately. People were also supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff knew people's preferences for their care and provided support in a respectful manner. Staff respected people's dignity and provided day to day choices for people.

Care plans included information about people's communication needs, and staff were aware of these. There was a complaints procedure in place and the provider responded to complaints appropriately.

The provider had systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people. People, relatives and staff reported the registered manager was available and responsive.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 25 August 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Graceful Care

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was conducted by two inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.
Inspection activity started on 9 March 2020. We visited the office location on 9 March 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager and office manager. We reviewed a range of records. This included 14

people's care records and medicines records. We looked at 11 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with nine people using the service, 16 relatives and six care staff.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Using medicines safely
• Medicines were generally managed safely but annual medicines competency testing was not in place. The provider told us a medicines competency check was completed by a test at the end of training and as part of the staff's shadowing during their induction. The provider also said they would use the competency check as part of the incident management process for medicines errors. The risk of all staff not having annual medicines competency testing was mitigated by regular spot checks of staff in people's homes, which included checking medicines competency if the staff member was on a call that required medicines administration.

We recommend the provider consider current guidance on medicines training and competency testing and act to update their practice accordingly.

• The provider had a medicines policy and procedure in place with guidelines to administer medicines safely.
• Staff completed medicines administration records (MARs) appropriately to indicate they had supported people to take their medicines as prescribed.
• The service audited MARs to ensure they were correctly completed by staff and medicines were being administered as directed.

Systems and processes to safeguard people from the risk of abuse
• The provider had systems and processes to safeguard people from the risk of abuse, including safeguarding adult policies and procedures in place
• People and their relatives told us staff provided safe care and support.
• Staff had up to date safeguarding training to help ensure they had the skills and ability to recognise when people were at risk of being unsafe and knew how to respond.
• The provider raised safeguarding concerns with the local authority where necessary and informed the CQC. Safeguarding investigations included outcomes, actions and lessons learned, which helped the provider to mitigate risk and help to keep people safe.

Assessing risk, safety monitoring and management
• The provider had systems and processes in place to help keep people safe including risk management plans to help reduce the risk of avoidable harm to people.
• Risk assessments covered a range of needs including, skin integrity, moving and handling and choking. The provider monitored these risks where required. For example, we saw staff recorded when they helped a person in bed to turn regularly to lessen the risk of pressure ulcers.

• The provider reviewed and updated risk assessments and management plans six monthly or when there were changes in people's needs.

Staffing and recruitment
• Staff logged their care visits using an electronic system and the provider monitored this to make sure people received their planned care. The provider also used the system to report on this weekly to the local commissioning authority. If a person's agreed hours of care needed to change, the provider tried to accommodate this and agree the changes with the local authority.
• The monitoring records showed some discrepancies between the times of care visits recorded in some people's care plans, the times arranged on staff rotas, and the time staff completed the visits. The provider explained this was because the local authority's information did not always match up with the time the provider had agreed with a person. They told us, when this was the case, they contract the local authority to have the time changed.
• Rotas indicated people received support from the same staff which provided consistency of care. One person confirmed this and said, "Because it's the same carer, they know what they are doing."
• The service monitored missed calls and had not recorded any since 2018. Comments included, "Sometimes [the staff are] early and sometimes [the staff are] late" and "Two [staff] at a time, at the same time and on time"
• Staff told us they had enough time to travel between calls.
• The provider had appropriate systems for the recruitment of staff to ensure new staff were suitable for the work they were undertaking.
• New staff members undertook an induction, so they knew how to work safely and effectively at the service.

Preventing and controlling infection
• The provider had appropriate procedures for preventing and controlling infection.
• Staff had relevant training and were provided with protective equipment such as gloves and aprons to protect people from the risk of infection.

Learning lessons when things go wrong
• The provider had a policy for responding to incidents and accidents. We saw systems to investigate and review incidents and accidents. Learning was recorded and where appropriate, staff practice was addressed.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance
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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

• Where people were able to sign their consent to care form, or where someone else had the legal authority to do so, consent forms were signed appropriately.
• The provider told us one person's mental capacity to consent to their care arrangements had deteriorated since they had previously agreed to their care plan. The person's care needs and plan had not changed, but the provider had not assessed the person's mental capacity or recorded they still considered the ongoing care plan was in the person's best interests. The provider addressed this immediately after our inspection visit.
• The provider had an MCA policy and staff received training on the principles of the MCA.
• People and relatives told us they were involved in making decisions about people's care and support. One person told us, "They usually assume that I would like [a shower]. [However,] I choose what I want to wear and point it out" and the person confirmed they chose what they would like to eat.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The provider assessed people's needs prior to beginning a package of care, to confirm these needs could be met safely. These assessments formed the basis of people's care plans.
• People's assessed needs included various levels of ability such as mobility, communication, washing and dressing, and sleep patterns and the care required for these.
• Protected characteristics under the Equalities Act 2010 were identified and recorded in people's care plans. These included people's cultural and religious needs. However, the quality of the information varied from detailed information to, '[Person] had no cultural or religious needs.

• People had signed to show that they agreed with their assessments

Staff support: induction, training, skills and experience
• Staff were supported to provide effective care through induction, training, supervision and spot checks.
• Staff new to care received an induction and training in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff new to care an introduction to their roles and responsibilities.
• Staff completed refresher training annually to keep their knowledge and skills up to date. Staff also received training specific to people's individual needs.
• Since the last inspection, the provider had employed an in house trainer, who in addition to mandatory training also undertook training with staff if this was an action from an incident form. The registered manager told us, since employing the trainer, their complaints had reduced.
• The provider completed regular checks of staff while they worked in people's home to monitor staff competency when delivering care.
• The provider had a 24 hour on call system, so staff could talk to a manager at any time for support. Staff told us managers were always available to provide support to them.
• The provider held team meetings for staff which gave staff the opportunity to reflect on their practice and raise any issues.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to have enough to eat and drink. The service did not prepare any meals but heated up food for people.
• Care plans included information about people's nutritional and dietary needs. Guidance had been provided for specific needs. For example, we saw one person had a care plan to meet their diabetic needs.
• We saw when a dietician was involved in a person's care there were clear guidelines for staff to provide support in this area.

Staff working with other agencies to provide consistent, effective, timely care
• Care plans included information about other health and social care professionals involved in people's care.

• We saw evidence in care records of staff working together with other professionals to achieve positive outcomes for people using the service. This included input from the dietician, community nurse and social services.

Supporting people to live healthier lives, access healthcare services and support
• People using the service were supported to have appropriate access to health care services. People had care plans for supporting them with their individual health needs. For example, one person's diabetic plan recorded, 'I will require my care worker to give me a sugary drink if I am going into hypoglycaemia (low blood sugar). Some of the symptoms are mood swings, weak spell, cold sweats, headache and heart palpitations.'
• Records indicated staff had contacted other health professionals such as the GP and podiatrist, where there were concerns about the person's health or wellbeing.
• People had hospital passports which provided relevant information to health professionals about the person and their needs in relation to medical care.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People and relatives generally spoke positively about the care they received. One person said, "The care is okay. I have no complaints." Relatives told us, "They're very good with my [relative]", "[My relative] is very fond of their [carer]" and "[The carers] are very careful. They're very nice and very friendly. They're certainly trying their best."
• The provider had an equality and diversity policy and staff respected people's cultural needs. For example, when a person died without family available to make their funeral arrangements, the registered manager organised this, because it was important to them that the person's dignity was maintained. They were aware the practice in the person's religion was for a swift burial, so the person's final wishes could be met.
• People's preferences for how they liked personal care was respected and they confirmed they were given the choice of a male or female carer.
• We found examples of people being cared for by staff who spoke the same language as them, which helped to ensure people were involved in their care.

Supporting people to express their views and be involved in making decisions about their care
• People and relatives told us they were involved in decision making. One relative said, "They call a meeting and ask us what we need. They're always in communication with us."
• Staff told us how they supported people to make choices. Comments included, "I have to treat people with respect and dignity. Before I start, I explain what I'm doing. Some people choose their clothes and some people choose their food. Depends on what they like, that's what I do" and "I ask them what they would like to eat even though I know what they usually have. I always ask questions to make sure their voices are heard."
• Care plans included information about people's preferences and choices and people were contacted either in person or by telephone to provide feedback about their care

Respecting and promoting people's privacy, dignity and independence
• Staff ensured people's privacy and dignity were protected when providing personal care. One person reported staff treated them with dignity and respect "very well".
• Care plans had guidelines for how to complete personal care tasks and noted staff should announce their arrival, ensure parts of the body not being washed were covered, to use different flannels and to support people with their chosen toiletries.
• Staff supported people to maintain their independence. A relative said, "[My relative] is fiercely independent" and told us staff encouraged their relative's continued independence.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

End of life care and support
• No one was being supported with end of life care at the time of the inspection.
• The provider did not have any records of people's end of life wishes. This meant people's wishes and preferences for care at the end of their lives were not always known in the event they required this support.
• The registered manager assured us, they would begin having conversations with people around end of life wishes and make a record to indicate what people's wishes were should the need arise.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• Care plans contained information and guidelines for staff so they could meet people's needs and preferences. One person said they had a care plan based on their assessed rehabilitation needs, and confirmed staff followed the care plan. Another person said, "[Staff] know my Africa food, yam and plantain. [They] know I don't eat pork." A third person's care plan provided details of their personal care preferences and, for example, included information on the use of shaving foam and where they liked to sit to be shaved.
• Reviews were held six monthly or when people's needs changed and the care plans were updated to reflect changes. One person told us, "We discuss the care plans sometimes and change it around." They also confirmed their opinions were listened to when this happens.
• Family and social background information provided staff with context and areas of interest when communicating with the person.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• Care plans included information about people's communication needs, including if they required assistive aids such as glasses or a hearing aid.
• There was a separate AIS page that provided guidance about how to communicate with people who had sensory impairments or a learning disability.
• Staff communicated with people in ways they understood. For example, the provider matched people with staff who spoke their first language. We saw one person's care plan had been translated into their preferred language. Another care plan indicated writing supported the person to communicate.
• A staff member told us they supported a person that did not speak English well, and they both used translation apps to communicate with each other.

Improving care quality in response to complaints or concerns
• The provider had a complaints procedure and information about how to complain was available to people in their service handbook.
• People and their relatives knew who to speak with if they wanted to raise a concern. One person said, "Never complained. Minor issues have been ironed out." A relative told us, there had been a problem with some staff putting things in the wrong place and other staff not being able to find it. They spoke with the registered manager who went to the person's home and resolved the issue.
• Records showed that when quality assurance phone calls to people were being undertaken, they confirmed people knew how to make a complaint if they needed to.
• Complaint records showed the issues recorded, the actions taken to address the immediate concern and the lessons learned to avoid repetition and improve service delivery.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People and relatives told us the provider promoted an open culture and was available to people using the service and to staff.
• Relatives generally spoke positively about the service and the care provided. One person said, "They always seem very helpful when I phone [the office]. They sort out any mis-understandings."
• Staff were happy with the support they received from the management team. One staff member said, "I think [the registered manager] is a good manager. They are very hands-on. If we raise a concern, they will resolve it. If clients have concerns, I pass it on to the management and they respond." Another member of staff told us, "[The registered manager] is very good and very involved with all of us and the clients. If we have an issue, they have no problem going to the client's home. They are always available even on the weekend."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The provider understood their responsibility around the duty of candour and of the requirement to notify appropriate agencies including CQC if things went wrong.
• The provider had policies and procedures in place to respond to incidents, safeguarding alerts and complaints and knew who to notify.
• People and their relatives knew who to contact if something went wrong.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The registered manager and staff team understood their roles and had a clear management structure. Since the last inspection the service had expanded and employed more senior staff that included an office manager, nurse, risk assessor and trainer. This helped to ensure staff had the required support to deliver a good quality of care and that there was ongoing monitoring to inform future practice.
• There were a range of policies and procedures which linked to relevant legislation and guidance. These were regularly reviewed and updated. The provider was also in the processes of implementing new templates that they had developed and improved in response to feedback, for example, through complaints and safeguarding alerts.
• The service had systems and procedures to monitor and assess the effectiveness of service delivery. This included spot checks and phone calls to get feedback from people using the service. The provider took

appropriate action in response to concerns raised in the feedback. For example, one person fed back they had not seen a field care supervisor. To address this, we saw a date was arranged for a field care supervisor to visit the person.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and relatives told us the provider regularly asked for their feedback through phone calls and home visits. A relative reported they had a visit and three phone calls from office since care the package began to check on their satisfaction. As a result, the frequency and times of the calls had been adjusted to better meet the person's needs.
• Team meetings were held to share information and give staff the opportunity to raise any issues. Additionally, there was a weekly meeting for field supervisors to discuss who they had visited during the week and to update records accordingly, so the service maintained relevant information about people.
• People's diverse needs, including protected characteristics, were considered as part of the assessment process. For example, people's communication needs.

Continuous learning and improving care
• The provider undertook several checks and audits that included medicines support, people's care records and staff files. The audits contained action plans and lessons learned to improve the service. The provider used colour coded data bases to monitor when tasks such as staff training were due to be renewed.
• The registered manager attended network forums to discuss current themes in social care and share and learn best practice.

Working in partnership with others
• The provider worked in partnership with various other health and social care professionals.
• Where appropriate they liaised with other relevant agencies, such as the local authority, dietician and community health care professionals to ensure people's needs were met.