Care at Home (Wearside) Limited

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 6 January 2017 and was announced. We gave the registered provider 24 hours' notice of the inspection because it is a community based service and we needed to be sure the office would be staffed.

Care at Home (Wearside) Limited is a domiciliary care service that provides personal care to people in their own homes. This includes care and support for people living with dementia. At the time of the inspection the service provided personal care services to 125 people.

The service had a registered manager in post at the time of inspection. 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 and their relatives told us they felt the service was safe. People had appropriate risk assessments in place and associated care plans.

The registered manager and staff were confident in their roles to safeguard people from abuse. Records showed staff members had alerted senior staff to situations where they felt people may have been at risk of or were being subjected to abuse. Safeguarding concerns were raised with the local authority in a timely way. Subsequent actions were taken from safeguarding concerns raised.

The registered manager understood the principles of Mental Capacity Act 2005 and had made referrals to the local authority requesting assessments and best interest decisions for people she felt were potentially vulnerable and lacked capacity to make specific decisions. The majority of staff had received up to date training in MCA and a plan was in place for the remaining staff. Members of staff we spoke with understood the importance of seeking consent from people prior to providing support.

Staff received regular supervisions and annual appraisals. Staff had up to date training with an ongoing plan to ensure training remained up to date.

People were supported to meet their nutritional needs. We saw people had eating and drinking risk assessments in place and people told us staff supported them by making meals and drinks. People had also been referred to the speech and language therapy team (SALT) for an assessment when required.

People told us staff were caring, lovely people. They were supported to be independent wherever possible and were supported to access the local community when receiving companionship as part of their personal care.

People had access to advocates where required. During the inspection we found one person was receiving

advocacy support. The registered manager informed us that if a person lived alone and had no relatives, they would support them to access a suitable advocate through the local authority.

People's care plans did not always contain sufficient information to guide staff in how to provide support to people safely. The majority of care plans were not personalised and did not contain people's personal preferences. The registered manager explained that a transition process was underway for all care plans to be transferred to a new, comprehensive template. We viewed some care plans that had completed this transition and found them to contain detailed guidance for staff including people's personal preferences.

People and their relatives knew how to complain and felt confident and able to do so. People spoke positively about the service and told us they had nothing to complain about. One person did tell us about a previous complaint they had which the registered manager resolved and they were happy with the outcome. We saw from records that complaints received were investigated and acted upon with outcomes fed back to complainants.

Care and senior staff meetings were held regularly to discuss service provision and ideas to improve quality. Newsletters were also sent to all staff members regularly to keep them informed of changes.

The registered manager had quality audits in place to monitor service provision and identify any potential improvements to develop the service further.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People and relatives felt the service was safe.

Staff were confident in their role to safeguard people. Safeguarding concerns were raised, investigated and acted upon.

Medicines were managed safely.

Staff were recruited safely and there were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff received regular supervisions and annual appraisals. Staff had up to date training.

People were supported to meet their nutritional needs.

People accessed healthcare professionals.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were "lovely people" and "like part of the family".

People were supported to meet their individual needs and to be as independent as possible.

People had access to advocacy services when required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The majority of people's care plans did not contain personal

preferences or sufficient information to guide staff.

People's needs were assessed prior to receiving a service. Assessments were used to create risk assessments and care plans where necessary.

People and relatives knew how to complain and would feel confident in doing so. Complaints were investigated and acted upon.

Is the service well-led?

Good

The service was well-led.

People and relatives spoke highly of the service.

The service held regular staff meetings to discuss the service. Newsletters were sent out regularly to staff to keep them updated with changes.

The service had systems in place to audit and monitor the quality of the service and inform ongoing improvement.

Care at Home (Wearside) 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 6 January 2017 and was announced. We gave the registered provider 24 hours' notice of the inspection because it is a community based service and we needed to be sure the office would be staffed.

The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We contacted the local authority commissioners of the service, the local authority safeguarding team and Healthwatch. Healthwatch England is the national consumer champion in health and care.

During the inspection we spoke with ten people and one relative. We also spoke with the registered provider, the registered manager, two supervisors and two support workers. We looked at five people's care records and 11 people's medicine records. We reviewed five staff files, including records of the recruitment process. We also reviewed supervision and training records as well as records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe with staff and the service they received. One person said, "I feel safe because they look after me and I would miss them if they didn't come. In fact I would be lost without them." Another person told us, "I feel safe when care staff are in my home because they're kind and caring." A third person we spoke with said, "[Staff member] is brilliant, they'll do anything for you. They'll spend time with me sitting and talking." A fourth person told us, "Oh yes I feel safe and comfortable with them (staff)."

The service had a range of policies and procedures to help keep people safe, such as accident, incident, safeguarding and whistleblowing procedures. These were accessible to staff for information and guidance. We found staff had received up to date training in safeguarding adults. Staff we spoke with understood how to safeguard people and were confident in their roles. We also saw from records that staff members had reported safeguarding concerns to supervisors when identified. The registered provider had an electronic record of safeguarding concerns. Records included alerts sent to the local authority, investigations carried out and actions taken.

Medicines were administered and managed appropriately. We looked at medicines administration records (MARs) for 11 people. We found that they had been completed in most cases by staff when medicines had been administered or offered. Where there were gaps we found these were due to reasons such as cancelled calls or no support was provided on those specific days. There was some incorrect use of key codes which had been identified by supervisors during audits and addressed with staff. Reasons for non-administration were recorded on the back of the sheets in most cases. Where non-administration had not been recorded, supervisors addressed these instances with staff and took appropriate action including arranging additional training and raising during supervisions.

We saw staff had received up to date training in the safe administration of medicines. Staff had medication competency checks carried out prior to administering medicines to people. The registered manager informed us and records showed that medicine competency checks were carried out every three months or more frequently if a member of staff's competence had been called into question.

Records in staff files demonstrated staff were recruited with the right skills and experience. Recruitment checks had been completed before new staff started working with vulnerable people. These included checks on their identity, health, references and a disclosure and barring service check (DBS). DBS checks are used as a means to assess someone's suitability to work with vulnerable people and to check that they were not barred from doing so.

We viewed a selection of electronic rotas to check enough staff were deployed. Each rota contained a list of carers with times of calls. We saw people had a consistent cohort of carers where possible. The registered manager told us that they tried to organise rotas so people were supported by the same team of care staff. This only changed if there was sickness or holidays or if people requested specific staff to provide support. People and their relatives told us there was enough staff to cover calls. One person told us, "They're usually the same girls who come each day. Except during the holidays but even then there's always one (usual one).

I feel very comfortable." Another person said, "It's always the same girls who come."

People had risk assessments in place where required. Risk assessments were reviewed and updated in line with people's changing needs. Care plans were in place for all identified risks but didn't always contain sufficient detail of how people should be supported to manage those risks.

Records of accidents and incidents were recorded in appropriate detail. Records included details of those involved, what had happened and details of action taken following an incident or accident. The registered manager maintained a log of falls people had suffered. Information included any injuries sustained, what action was taken and what preventable measures were put in place to reduce reoccurrences. For example, referrals to the falls team or revised care plan.

Good

Is the service effective?

Our findings

The provider had a policy and procedure in place for each staff member to receive an annual appraisal. The registered manager told us and records confirmed that all staff who were due to have appraisals had received them. Those staff who had been employed for less than one year had appraisals scheduled in the appraisal and supervision plan. Records showed that appraisal discussions covered staff members' performance, strengths, weaknesses and future learning and development. Actions agreed were recorded on appraisal forms. For example, to complete an NVQ Level 2 in Health and Social Care.

People and relatives we spoke with said they felt staff had the skills to do their job. One person we spoke with told us, "The staff are trained properly. They're very good." Another person told us, "The staff are excellent in my eyes." A third person said, "The staff are brilliant. I couldn't ask for a better team." We asked one relative if they felt staff were skilled. They said, "Yes I think so."

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.

We checked whether the service was working within the principles of the MCA. The registered manager and staff understood the principles of MCA and gaining consent before care and support was provided. The registered manager told us, "I know we have to assume they (people) have capacity. If we suspected a person of lacking capacity we would refer them to the local authority for an MCA assessment." They went on to tell us, "I have just made a referral to a social worker for a mental capacity assessment to be carried out for another service user."

At the time of our inspection there was one person receiving a service who potentially lacked capacity to make specific decisions. We noted the registered manager had made a referral to the social worker who was due to complete an MCA assessment and best interest decision in relation to the person's finances. Staff we spoke with had an understanding about gaining consent from people and to speak with supervisors or the registered manager if they felt someone was lacking capacity to make decisions. One staff member told us how they supported people to get ready and gave them choices of clothing to wear.

From the training matrix provided, we saw the majority of staff had received up to date MCA training. The registered manager told us training for the remaining staff was scheduled to take place on 8 February 2017. We will follow this up outside of the inspection process.

Records showed staff training was up to date in subjects including safeguarding, medicines administration and moving and handling. The training matrix showed that a number of staff had also received training in other areas such as dementia, fire safety and food hygiene. We noted there were some gaps in the training matrix for some staff. The registered manager informed us that some mandatory training was not detailed

on the matrix for new staff as they had received the training as part of their induction and through ongoing completion of the care certificate.

All staff received a structured induction at the beginning of their employment which then led to the care certificate. The care certificate is a set of standards that social care and health workers work to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. The registered manager told us and records confirmed that new staff received a three day induction delivered internally by senior staff. The induction included all mandatory training and shadow shifts with experienced staff. Shadowing was observed by the supervisors who assessed the practical delivery and approach staff had towards people and the support they delivered.

Records showed staff received regular supervisions. We looked at supervision records and found that discussions included knowledge of duties and application of those, communication, approach to work, team work, health and safety, safeguarding and whistle blowing.

As part of the supervision process spot checks were carried out on staff members to assess their performance around interaction with people. Spot checks looked at general care, communication, appearance of staff, records and infection control. We noted issues included staff not wearing ID badges and not always wearing aprons. Actions were recorded which included the assessor providing staff with additional aprons for infection control purposes and addressing with staff the importance of ensuring they wore their ID badges in future.

Records showed people had received support from a range of health professionals including GP's, SALT, Falls Team, district nurses and occupational therapists.

People were supported to meet their nutritional needs. One person said, "The staff come in every morning and make sure I'm okay. They make me coffee and toast." We saw people had eating and drinking risk assessments in place where required and associated care plans. One staff member told us, "I always ask [person] what they want to eat before I make their dinner." They went on to tell us that they also get to know people's likes and dislikes through supporting them over a period of time.

Good

Is the service caring?

Our findings

We spoke with people and relatives about whether they thought the service was caring. They told us they were happy with the care they received from the service. One person said, "The staff are champion. I've got no worries whatsoever." Another person told us, "The staff are all lovely people." A third person said, "I love having a chat when the girls come." A couple who received the service told us, "They're all right, they're nice enough girls." A relative we spoke with said, "They're lovely girls, they're like part of the family. Anything you want they'll do for you."

Staff supported people to meet their individual needs and preferences. One person said, "They come in and they're very willing and very clean. They always ask "is there anything else you need." Another person told us, "They always make sure I have my tablets from my nomad on a morning and a teatime." A relative told us, "They just do everything for (family member). On a morning they get (family member) up and get them showered, dressed and in their wheelchair ready to go out."

During the inspection we noted that some staff members had previously won a carer of the year award from an external association. To be entered for the award staff members had been nominated by people receiving a service or their relatives.

Staff were issued with a handbook on commencement of their employment which included information and guidance about the service. Induction training was delivered to staff which covered privacy, dignity and confidentiality. The service also had policies and procedures in place for staff to access. Dignity in care was also raised in staff meetings to remind staff of their duties.

People were supported to be as independent as possible. One person told us, "If I can manage to do things myself I will. But they always offer and I would ask if I couldn't manage. If I need anything doing, I only have to ask."

People accessed the local community with staff support, with tasks such as shopping as well as activities to meet their social needs. A supervisor told us that some people received companionship as part of their personal care. Companionship was used for specific activities such as supporting someone to go food shopping or supporting someone to a football match. The supervisor told us, "Some are more specific and for others the carer asks the person on the day. It's up to them what they want to do." They went on to tell us it could be for staff to support people to go for a walk in the park or to a café for a cup of tea.

At the time of the inspection one person had an advocate in place following a safeguarding concern. When speaking about people who may be found to lack capacity the registered manager told us, "If someone lived on their own and didn't have family we would contact their social worker and arrange an advocate through them." The registered manager went on to tell us they would still go through the local authority to arrange advocates for those who didn't have a social worker.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to receiving support from the service. Staff visited people to collect their personal information as well as complete assessments of their needs. Information included a personal history, hobbies and interests. People's needs were assessed around personal care, eating and drinking, communication and medicines. The assessments helped to inform risk assessments and care plans for people.

We looked at five people's care records held in the office and found they varied in detail. Some care plans were detailed, personalised to the individual and contained information around their preferences. Other care plans consisted of a basic list of tasks and did not demonstrate involvement from the person receiving services because of the lack of detailed preferences. The majority of care plans did not give clear information and guidance of how care and support was to be provided. People's preferences, likes and dislikes were not recorded in most cases. This meant detailed information was not always readily available to guide staff how to support people.

We spoke with the registered manager about care plans and the lack of detail. The registered manager told us, "We are in the process of re-writing all the care plans because I identified that they are basic and I want them to tell a story. The registered manager told us, "We've started with the care plans for people with more complex needs and then will roll out to all of the others." At the time of the inspection 23 people's care plans had been revised using the new template, some of which we had reviewed. The registered manager had a plan in place and confirmed that all care plans would be re-written using the new documentation by the end of March 2017. Care plans were reviewed on a sixth monthly basis or more frequently if required, in line with people's changing needs.

Supervisors completed face to face meetings with people and their relatives every six months to discuss their care and support and obtain their views and thoughts. One of the areas the supervisors asked people was around the duration of their calls and if they felt the calls were long enough to meet their needs. From records we viewed we found one person stated the call wasn't long enough to see to their personal care and breakfast on a morning. The supervisor contacted the person's social worker who agreed to additional time for the morning call. The person's plan and staff rotas were updated to reflect the change.

People and relatives knew how to raise concerns if they were unhappy about their care or the care their relative was receiving or the service in general. One person said, "I have no complaints whatsoever. If I had a complaint I would ring the office straight away." Another person told us, "I've no complaints about the staff at all." A couple who received a service told us, "We have no objections about the girls. We have no concerns or complaints about the service." One relative we spoke with said, "I have no complaints about them, they're good people. There was once I raised an issue about a carer with the registered manager and they never came again. They're good like that."

We viewed the registered provider's complaints log which contained one complaint about the service in the last 12 months. We saw the complaint was recorded, investigated and outcomes were fed back to

complainants and other relevant parties. The action taken by the provider was recorded and included speaking with staff, implementing an additional procedure and changing rotas.

The registered provider recorded when people contacted the service with requests or informal complaints. Records included the nature and detail of the call and what action was taken. We noted people had contacted the service to request specific members of staff to provide their care. Reasons given included they really liked them and engaged with them better than others. We saw rotas had been changed following requests, where possible. In cases where changes for particular staff were not possible, this was communicated to people and recorded.

Good

Is the service well-led?

Our findings

The registered provider had systems in place to check on the quality of the care people received. Checks carried out included medication audits, accident monitoring and analysis and safeguarding monitoring. Specific spot checks were carried out on staff and included the general appearance of the care worker, whether they wore their identity badges and if they supported the person in accordance with their care plan. Other areas included documentation, reporting concerns and staff member's approach. From the spot check records we viewed, there were no actions required. The registered manager informed us the registered provider visited the service at least once per week to discuss any issues with the registered manager and to touch base with how things were going.

People and relatives spoke highly of the service. One person told us, "I'm over the moon with the care I get." Another person said, "I really can't see how it (the service) could be improved at all." A third person told us, "I'm totally satisfied with the service I get. It's a good job there are services like this." A fourth person told us, "It's champion." A fifth person said, "I'm quite satisfied, thank you."

The home had registered manager who had been in post since March 2016. They were proactive in meeting their responsibilities in relation to submitting relevant notifications to the Care Quality Commission.

The registered manager told us they operated an open door policy at the service to enable and encourage staff to approach either themselves or the supervisors with any requests, concerns or issues. Staff told us they felt the registered manager was open and approachable. During the inspection we saw staff members come into the office and approach supervisors and the registered manager to have discussions related to their work.

The provider had out of hours arrangements in place to ensure staff members were able to contact a member of management if necessary. The registered manager informed us that out of hours arrangements were organised on a weekly rolling rota between the two senior carers and two co-ordinators. The allocated senior person covering had the company mobile phone which all office phones were transferred to. They also had a list of every person's name and addresses, details of key safe numbers, copies of rotas and details of all carer's names and telephone numbers. Staff were aware of the arrangements and to ring the office number at any time for guidance, to phone in sick, to request assistance or advice. If a senior care worker or co-ordinator couldn't answer the query, they would ring the registered manager.

The provider had a system in place for staff covering out of hours to provide a daily handover of information to other senior management. Written handovers were completed during each period of out of hours cover. Details included, time of call, reason for call and what action was taken. For example, one person called on an evening to cancel their night call. The staff member on duty checked the rotas and contacted the staff member who was due to go to the person's house to complete their night call. The covering staff member then updated the electronic system on return to the office the next day to record the cancelled call, including the reasons why.

The registered manager held regular meetings with staff to discuss the service and to give staff the opportunity to raise any issues they had. We viewed minutes of staff meetings and noted discussions around MAR charts, communication, confidentiality, people, safeguarding and dignity in care. The service also held regular senior team meetings to discuss areas such as contracts of services from local authorities, job roles, communication and culture of staff.

Newsletters were created regularly and circulated to all staff to keep them informed of things happening in the service. The registered manager informed us that they tried to send newsletters out on a quarterly basis. Newsletters contained information such as out of hours telephone numbers, new staff recruited, distance learning course opportunities, the provider's organisational chart and acknowledgements of staff who had received an external carer's award.

The service had received a number of compliments and thank you cards from relatives of people who had previously received a service. One thank you card stated, 'Just a few words to express our deepest appreciation for all the love and care that you gave [family member] and also [another family member]. Every detail was attended to and you all went above and beyond the call of duty.' Another thank you card received stated, 'To all the wonderful staff at Care at Home (Wearside) who provided such a fantastic service to [family member] throughout their brave battle. We would like to thank all the carers for the genuine care and attention given to [family member] with respect and dignity to the end. Your warmth and support was a great help to all of the family and we are very grateful to you all.'

The service regularly sought views from people and their relatives in relation to the quality of the service. Supervisors met with people and their relatives face to face every six months to discuss the quality of the care and support they received. Specific questions included time keeping of staff, if they were happy with care and care plans, were they treated with respect, carer attitude, any complaints and any other comments. We saw from records supervisors and the registered manager took action if people weren't happy or satisfied with a particular aspect of the service.

The registered manager informed us they had sent out surveys to every person who received a service in November 2015. Unfortunately, they hadn't received any responses but felt confident they collected people's views through the six monthly face to face meetings.