Care Outlook Ltd

Care Outlook (Brighton and Hove)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Care Outlook (Brighton and Hove) is a domiciliary care agency. It provides personal care to approximately 141 people living in their own homes in the community. Care Outlook (Brighton and Hove) supports people with a range of health and social care needs, such as people with a physical disability, sensory impairment or people living with dementia. Support was tailored according to people's assessed needs within the context of people's individual preferences and lifestyles to help people to live and maintain independent lives and remain in their homes. 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:
Care Outlook (Brighton and Hove) provides a service to people living in the areas of Brighton and Hove and other parts of Sussex. On the whole, people receiving care in Brighton and Hove were happy with their care. However, people we spoke with living in the mid-Sussex areas were not happy with the care they received. They felt they were treated with kindness by their care workers and they felt safe, however, they did not feel the care received met their needs and preferences. People's care visits were often late or early and on occasion cut short. Systems for scheduling care visits did not reflect people's assessed needs or preferences and did not provide continuity of care.

Systems were in place for the recording of incidents and accidents. However, we could not see evidence that incidents and accidents were followed up, monitored and analysed over time to recognise any emerging trends and themes, or to identify how improvements to the service could be made.

The provider had systems of quality assurance to measure and monitor the standard of the service and drive improvement. However, these systems had not ensured the areas of improvement identified at this inspection had been acted upon and prevented.

People's feedback was mixed in respect to feeling the service was well managed. They did not feel routinely involved in their care, or feel their concerns and issues were acted upon.

The provider was aware of the issues we identified at this inspection and had started to implement improvements.

People's medicines were managed appropriately and staff followed infection prevention and control (IPC) procedures to keep people safe. Staff told us they felt supported in their roles and said they liked working at the service.

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 18 October 2017).

Why we inspected
We received concerns in relation to the service providing regular care calls that met people's needs and preferences. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Care Outlook (Brighton and Hove)

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team:
The inspection team consisted of one inspector and an Expert 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. It provides a service to older adults and younger adults with physical disabilities.

The service did not have a manager registered with the Care Quality Commission (CQC). Registered manager's and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, a manager was in post and was in the process of registering with the CQC.

Notice of inspection:
The inspection was announced. The provider was given short notice of inspection. This was because the location provides a domiciliary care service and we wanted to be sure that someone would be in to speak with us.

What we did:
On this occasion we did not ask the provider to send us the provider information return. This is information providers are required to send us with key information about their service, what they do well, and

improvements they plan to make. This information helps support our inspections.

We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as incidents and abuse. We used this information to plan our inspection.

During the inspection:
We reviewed a range of records. This included three staff recruitment files, training records, accident and incident recording, and records relating to the scheduling of care calls and the management of the service. We also viewed a variety of policies and procedures and quality assurance processes developed and implemented by the provider. We reviewed four people's care records. We spoke with eight members of staff, including the provider, the manager, and administration and care staff. During our inspection we spoke with six people and two relatives over the telephone.

Requires Improvement

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 Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

• At the last inspection, we identified concerns in respect to references being taken up appropriately for new staff. We saw that improvements had been made, and records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained, and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector.

• Enough skilled and experienced staff were employed, however, we found that in the mid-Sussex areas covered by the service, staff were not deployed in a way that met people's needs and ensured their safety. We received negative feedback from people receiving care in the mid-Sussex areas in relation to staffing levels, and staff arriving at appropriate times to assist people with their care. A relative told us, "We don't know when they are coming, no idea what time the calls are booked for, it's not clear. The morning call can be as early as 7:30am and as late as 10:45am. It is difficult to plan the day, very unsettling. My [relative] is incontinent, she likes to go to bed at 7:00pm. If they are late arriving in the morning, she is likely to have spent 15-16 hours in bed." Another person said, "They usually come from about 9:30am onwards to get [my relative] out of bed and onto the commode. Lately it has been 10:30am, last weekend it was 12:15pm. [My relative] shouts out because he needs the commode and I have to manage him myself if they are late. At night they are supposed to come between 6:30pm and 7:00pm to put him to bed, they arrive at about 9:00pm and because he is tired and wants to go to bed I have to put him to bed on my own." A further person added, "I complained to the office and they said they were short staffed at weekends, but I don't think I was taken seriously."

• Feedback from staff stated they felt the service had enough staff to meet people's needs, and they received regular rotas, with any changes to times passed onto them.

• However, feedback from people and our own observations of the rota system used in the office did not support this. We saw that call times scheduled in people's care plans did not match those scheduled on the system, or the actual times that the visits were going ahead. People were at risk of receiving care that did not meet their needs. We spoke with the provider and staff about how they ensured that people got their care visits when they were scheduled to take place. They said the current system of scheduling calls and allocating care staff was in need of change and that it was a 'work in progress'. Changes had begun to be implemented, however we have identified this an area of practice that needs improvement.

Learning lessons when things go wrong

• Staff understood the importance of recording all incidents and accidents. Documentation included information on the time, location, nature of the incident/accident and who was involved.

• However, we could not see evidence of what further action had been considered or taken place subsequently to mitigate the risk of re-occurrence and keep people safe.
• Staff were aware these systems needed to be in place and told us they had plans to implement them. However, we have identified this as an area of practice that needs improvement.

Systems and processes to safeguard people from the risk of abuse
• People said they felt safe and staff made them feel comfortable. One person told us, "I feel safe, they talk to me, they don't do anything without telling me first."
• Staff had a good awareness of safeguarding and could identify the different types of abuse and knew what to do if they had any concerns about people's safety.
• Information relating to safeguarding and what steps should be followed if people witnessed or suspected abuse was available for staff and people.

Using medicines safely
• Care staff were trained in the administration of medicines and people were supported to receive their medicines safely. We saw policies and procedures used by the provider to ensure medicines were managed and administered safely. One person told us, "I kept forgetting my tablets, so they give them to me morning and evening. They put them in a cup and give them to me, they check that I have taken them, they stay with me, they also hand me my inhaler to take."
• Medicine risk assessments were completed to assess the level of support people required.
• Audits of medicine administration records (MAR) were undertaken to ensure they had been completed correctly, and any errors were investigated.

Preventing and controlling infection
• We were assured that the provider was using personal protective equipment (PPE) effectively and safely. One person told us, "The staff wear gloves, aprons and masks."
• We were assured that the provider was accessing testing for staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the office premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.

Assessing risk, safety monitoring and management
• Detailed risk assessments had identified hazards and guided staff on how to reduce or eliminate the risk and keep people and staff safe. For example, an environmental risk assessment included an analysis of a person's home inside and outside. This considered areas such as the risk of trip, slip or fall for either the person or the staff member.
• Other potential risks included the equipment people used and how staff needed to ensure they were used correctly and what to be aware of. Risk assessments were up to date and appropriate for the activity.
• The service planned for emergency situations, such as inclement weather. Additionally, the service operated a 24 hour on call service to support both people and staff.

Requires Improvement

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 deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• People were placed at risk, as systems and processes in place to ensure people received their calls in line with their needs and preferences were not robust or appropriate.

• People receiving care in the mid-Sussex areas covered by Care Outlook (Brighton and Hove) gave us negative feedback in relation to when their care staff arrived to support them and how this had an adverse effect on their care and wellbeing. One person told us, "We never know when they are going to arrive, it's very difficult especially if they arrive when I am in the middle of a meal." Another person said, "I haven't a clue what time they are going to turn up, it's all different times."

• They told us their care staff sometimes did not stay for the amount of time they were allocated to care for them. One person told us, "I think it's about half an hour they should be with me, some are in and out in five minutes." Another person said, "They stay about half an hour to shower and dress me. Some do a bit of washing up and make me a cup of tea, not all of them. My regular carer just does the bare minimum." A further person added, "Something is not right lately, sometimes they come in pairs, sometimes they don't, it's hit and miss".

• Individual care plans had been developed. Care plans contained personal information, which recorded details about people and their preferences. This information had been drawn together, where possible by the person, their family and staff. Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person-centred care. People receiving care in Brighton and Hove we spoke with who were happy and felt the care met their personal preferences.

• However, feedback from people receiving care in the mid-Sussex areas and our own observations of their care plans and the rota system used in the office did not support this. We saw that information in people's care plans in respect to their preferences around call timings and tasks they wished to be supported with did not match the care that was scheduled and delivered.

• We spoke with the provider and staff about how they ensured that people got their care visits when it suited them. They said the current system of scheduling calls was in need of change and that it was a 'work in progress'. Changes had begun to be implemented, however this is an area of practice that requires improvement.

The provider had failed to ensure that people received care that was appropriate, met their needs and reflected their preferences. This is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

• People knew how to make a complaint and told us that they would be comfortable to do so if necessary. One person told us, "I phoned the office three months ago because I was unhappy with my carer. He was always on the phone even when I was talking to him. They haven't sent him since I complained."
• The procedure for raising and investigating complaints was available for people in their homes, and staff told us they would be happy to support people to make a complaint if required.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• Where it was funded, or part of a person's care plan, staff supported people to enjoy activities and socialise. Staff got to know people well and took an interest in the things they liked to do.

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.
• People's communication needs were identified, recorded and highlighted in care plans. These needs were shared appropriately with others.
• We saw evidence that the identified information and communication needs were met for individuals.

End of life care and support
• Nobody was in receipt of end of life care, however, we were told that peoples' end of life care would be discussed and planned, and their wishes were respected should this be required. Staff had been trained to support people at the end of their life.

Requires Improvement

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 deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• The service had been without a manager registered with the CQC since January 2020. Registered manager's and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. A manager was in post and was in the process of registering with the CQC. However, a significant amount of time had passed without the provider meeting this condition of their registration.

• Systems of quality monitoring and governance had not ensured that people received care that met their needs and preferences and drove improvement.

• Systems to schedule care visits in line with people's preferences were not robust. Mechanisms were not in place to monitor incidents and accidents on a regular basis over time to help identify any emerging trends or themes, so that patterns with common causes could be identified and prevented.

• People's feedback had not always been acted upon to improve the service. People told us that on the whole they got on well with the care workers who came to see them. However, in respect to people receiving care in the mid-Sussex areas, we received mixed feedback in relation to how the service was run. One person told us, "I am happy with the carers I get." However, another person said, "Nothing is done properly, staff don't introduce themselves, they talk to each other about their families, instead of talking to me." A further person added, "The agency could be managed better. There needs to be much more communication, I take it upon myself to communicate with them."

• The provider and staff told us the care of people using the service was the most important aspect of their work and they strived to ensure that people received high quality care. Our own observations of systems and processes in place and the feedback from people we received did not support this.

The provider had not ensured they had effective systems and processes in place to assess and monitor the quality of their service, and to make sure this happened at all times and in response to the changing needs of people who use the service. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Senior staff undertook quality assurance audits. We saw audit activity which included health and safety and medication. The results of which were analysed in order to determine trends and introduce preventative measures.

• Policy and procedure documentation was up to date and relevant in order to guide staff on how to carry

out their roles.
• Staff commented they felt supported and had a good understanding of their roles and responsibilities. A member of staff told us, "We all support each other, I can go to my manager with anything." Another member of staff said, "We give good care to people in their homes and we work hard to do that."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• There were systems and processes followed to consult with people, relatives, staff and healthcare professionals. However, we received mixed feedback in respect to people being actively involved in their care and developing the service. One person told us, "The office contacts me on odd occasions to ask if I am happy, they last called a few months ago." However, another person said, "The office doesn't let me know of any changes, I have to phone them." A further person added, "A carer told me that [my relative's] hours have been cut. I contacted the agency and told them what I had heard, and they told me that they are monitoring things because [my relative's] needs are not as high as they first thought. It was wrong that the carers told me and not the management."
• We spoke with the provider about this and they confirmed that all people using the service were in the process of receiving a review to determine their required care needs and satisfaction with the service. We saw that staff meetings and satisfaction surveys were carried out, providing management with a mechanism for monitoring satisfaction with the service provided.

Continuous learning and improving care
• The service had a good emphasis on team work and staff commented that they all worked together and approached concerns as a team. One member of staff told us, "We all help each other out, I think we have a good team." Another member of staff added, "I have full faith in my colleagues and my manager."
• Staff had a good understanding of equality, diversity and human rights and explained how they would make sure that nobody at the service suffered from any kind of discrimination. Feedback from staff indicated that the protection of people's rights was embedded into practice, for both people and staff, using and working at the service.

Working in partnership with others; 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 service liaised with organisations within the local community. For example, the Local Authority and Clinical Commissioning Group to share information and learning around local issues and best practice in care delivery.
• Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had.
• Staff were aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people received care that was appropriate, met their needs and reflected their preferences. Regulation 9(1) (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure they had effective systems and processes in place to assess and monitor the quality of their service, and to make sure this happens at all times and in response to the changing needs of people who use the service. Regulation 17(1)(2)(a)(b)(e) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.