Quality Care Resourcing 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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 8 March 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service. At the time of the inspection Quality Care Resourcing provided domiciliary care and support for 13 people in their own home. The service worked primarily with older people all of whom were living in Essex.

This was the first inspection of the service since registration in September 2016. As a result of this inspection the service was rated as Good.

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 older adults and younger adults with disabilities. CQC inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager in post. A registered manger is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of law; as does the provider. The registered manager was present during the inspection.

Procedures relating to safeguarding people from harm were in place. A member of care staff told us that they understood what to do to keep people safe from harm. Staff had training about the systems in place to protect people who could not make decisions and the legal requirements outlined in the Mental Capacity Act 2005.

The service operated safe staff recruitment procedures and ensured that all staff were suitable for the role before beginning any direct care work with people using the service.

Medicines were managed safely and the service had a detailed policy for managing, recording and auditing the safety and effectiveness of medicines management.

Risk assessments provided staff with guidance on how to mitigate people's individual personal risks. Risks had been clearly identified and risk reduction measures were identified and acted upon.

Staff were provided with a suitable induction as well as on-going regular training and supervision to support them in their role.

People were involved in planning their care and had regular reviews to gain their opinion on how things were. Care plans were person centred and included information on how people wanted their care to be delivered as well as their likes and dislikes.

People and their relatives were provided with information on how to make a complaint and their views were

obtained and acted upon. People were treated with dignity and respect and trusted the staff that supported them.

People who used the service, relatives and stakeholders had a range of opportunities to provide their views about the quality of the service and the provider monitored the performance of the service.

Further information is in the detailed findings below.

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. Staff were provided with training and guidance to enable them to recognise abuse and how to report it.

Risk assessments provided staff with appropriate guidance on how to keep people safe and this included medicines management. Medicines were managed safely.

The provider followed safe staff recruitment practices and people received a continuity of care and on most occasions had the same staff visiting them.

The provider had taken steps to understand and learn from any incidents that occurred for future reference.

Is the service effective?

Good

The service was effective. People's needs were assessed in consultation with them and their family if appropriate.

Staff received regular training and an induction before commencing their work.

The service worked in line with the Mental Capacity Act 2005 (MCA) and recognised how this influenced the care that they provided.

People were supported to have enough to eat and drink so that their dietary needs were met.

Is the service caring?

Good

The service was caring. People were treated with respect and staff maintained privacy and dignity.

People were encouraged and supported to have input into their care and their views were respected. We were informed that care staff responded with kindness and respect for people and paid attention to them when providing care.

Is the service responsive?

Good

The service was responsive. People's care was person centred. Care was planned in collaboration with people, which people and relatives confirmed.

The provider monitored the care provided to people using spot check visits and regular phone calls to people to ask them about the quality of their care.

People knew how to make a complaint. There was an appropriate complaints procedure in place and the provider responded to any complaints or comments that were made.

Is the service well-led?

Good

The service was well led. People were asked about their views about the support they received from the service.

The registered manager had a monitoring system in place to ensure care was assessed, audited and that people's needs were met.

People's views were obtained and were acted upon.

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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 8 March 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the registered manager would be present. The inspection was carried out by one inspector and an expert by experience that carried out telephone interviews with people using the service and relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at information that we had received about the service and any formal notifications that the service had sent to the CQC. We looked at three care plan records and risk assessments, four staff files, personnel records and other documented information related to the management of the service. We asked the provider to complete a Provider Information Return (PIR) which they did. 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.

During our inspection we made contact with four people using the service and two relatives of other people who could give views on their behalf. We spoke with the manager of the service. We received one e mail from a member of care staff in response to our request for feedback from all staff. Prior to this inspection we contacted the local authority that commissioned all of the care packages that the service provided and they replied very positively about the quality of the service provided.

Good

Is the service safe?

Our findings

People using the service told us, "Yes, they always come in twos [meaning two care staff they need]. It's support for each other and me especially if they come to the house it could be risky especially if they go somewhere new." and "Yes certainly, well they sometimes ask me if I'm in pain and several other bits and pieces generally speaking, I think their service is absolutely excellent."

In addition two people using the service told us that care staff had arrived when expected even during a recent spell of bad weather, which people evidently appreciated.

The service had a safeguarding policy that described the definition of safeguarding and the ways in which the service would respond to any concerns. The policy and procedure outlined that people had the right to be protected from abuse regardless of their heritage or other diverse needs and that people had the right to expect that they would be treated with dignity and respect. Types of abuse and the action that must be taken if abuse was suspected were also described. Staff were trained in safeguarding during their induction and had received this training prior to beginning to deliver care. No concerns had been raised about the service since it had begun to operate.

The member of the care staff team that contacted us said "The service is very safe and any reported concerns are dealt with promptly and effectively by my supervisor."

We viewed three people's risk assessment and care assessment records. We found in each case people had risk assessment and risk reduction measures included in their care plan files. These were tailored to environmental common risks and any personally identified risk that the service needed to consider when providing care. Most people had only begun using the service in the last six months. The provider's risk assessment policy stated that risk assessments should be reviewed regularly. A good example of how risk assessments and action taken to reduce risks was seen in respect of one person who had highly complex care needs. This person's physical condition meant they were at very high risk of choking and required care from agency staff 24 hours a day. The risk this person faced had been considered in detail and the action care staff were taking to minimise this risk was clearly described.

The service followed safe recruitment practices. Recruitment files showed pre-employment checks, such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. Where staff members required home office permission to work in the UK, this was documented. This minimised the risk of people being cared for by staff who were inappropriate or unsuitable for their role.

We looked at the arrangements in place to cover the care needs and call times that had been agreed with people. The service required staff to log their arrival for each visit via a call monitoring system, which they did. We were told that this system usually worked well, although there had been some recent technical problems which they were resolving with the company providing the monitoring system. Along with the on call out of hours contact number this meant that any risk of missed or late calls were quickly responded to.

Training records showed that all staff had undertaken medicines training since starting to work for the service. Annual checks of competency were a part of this policy but would be undertaken sooner if any issue was identified, although to date no medicines errors had occurred.

We were told by the registered manager that six people required assistance to take medicines. We looked at copies of medicines records for three previous months and these were fully completed. People that required assistance to take medicines had fully completed records of administration including the medicine, the strength, and time to be taken and initial of the staff member that provided assistance each time.

All staff were provided with personal protective equipment such as gloves and aprons supplied by the provider. We were informed by the registered manager that no-one using the service had any communicable illnesses or other conditions. Staff were required to use the equipment provided when carrying out personal physical care, including personal protective equipment such as disposable gloves and aprons which were supplied to care staff by the agency.

No significant or notifiable incidents had been reported to CQC since the service was registered. Our check of this during the inspection confirmed that no incidents had occurred.

Good

Is the service effective?

Our findings

People using the service told us "Yes [care plan] was set up when he left hospital last year through social services and if we want something changed we just talk to them and it gets changed." and "'When they come in the morning I say ok girls everything is ready for you to carry on. If anything is not right they will say. I trust them enough to get on with it."

All people's care plans we looked at had been compiled in recent months as they begun to use the service, all started with a comprehensive assessment of need. The registered manager informed us that reviews were carried out at least annually but sooner should anyone's care and support needs change and their circumstances required this to happen. This was referred to in the care plan policy. The involvement of people, and their relatives if also involved, was included in care plans and consent to care had been obtained.

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 was aware of, and understood, their responsibilities in relation to meeting the requirements of the MCA and the service assessed people's mental capacity. People's mental capacity had been documented and included in their care plan records. Where people were unable to be involved in planning their care, relatives had been consulted and the person's best interests had been considered. This was referred to in people's care records and the details of who had been involved and their relationship to the person were also included. People using the service and relatives were very clear that care staff made records of the care that had been provided and wrote these in a file kept at each person's own home.

The service was clear about obtaining consent to care and had done so in all of the care plans that we viewed. These people had all consented themselves to their care and had not required anyone else to do so for them. People, and where relevant, relatives were consulted about care assessments and care plans. This involvement was recorded on assessments and care plans as often relatives might be present when these discussions were held.

Care staff received regular supervision. Many of the care staff were new and had only recently begun to have supervision. Records of staff supervision confirmed the three month frequency for longer term staff in line with the provider's supervision policy.

The 13 care staff who were currently working with the agency to provide care were appointed within the last twelve months. Most of these staff were part time employees. An annual appraisal would not have yet been required for any of the care staff.

Induction included training in line with the Care Certificate, which is training for care workers which provides the fundamental knowledge and skills for people working in care services. Staff induction covered necessary core skills, for example, medicines, moving and handling and keeping people safe from harm. Induction commenced with working through a pre prepared induction programme and included three day shadowing of an experienced care worker. The length of shadowing depending on the experience of the person and the mentor reported how ready the staff were to begin working with people.

The member of care staff that contacted us said "The training is comprehensive and is followed by several days of shadowing with either a senior carer or a supervisor."
People were supported with their nutritional needs where required. A person using the service told us 'Well, kind of, yes they do, yes they microwave it I don't have an oven." A relative told us "We usually leave my [relative's] food for care staff in the fridge and they microwave it and they do toast the weekends and a bowl of muesli in the week." Care staff usually only provided light meal preparation for people where this was required. This was heating food up for people or making a light snack such as sandwiches. All staff had been trained in food hygiene and nutrition.

The registered manager informed us that care staff did not routinely attend healthcare appointments with people as this was managed by people themselves with assistance from their family. The registered manager stated that supporting people with these appointments would be considered if there was no-one else who could support the person, although this had not been necessary to date.

Good

Is the service caring?

Our findings

People and relatives were invariably positive about the attitude of the staff. People said "Yes I think so because they try to make me feel not so stressed because I get stressed out, they try to calm me down and don't make it worse for me." and "'Yes, think they do everything they can really."

From the views that people shared with us it was evident that care staff respected people's dignity and privacy when providing personal care. Most people did not tell us in detail about whether they believed their dignity and privacy were respected, however, from the overall comments that were made these areas were not anything of any concern to people.

A relative told us "Yes if the bathroom door is open, they will close it. They will close the bedroom door also if anybody walks into the house they will not see what's going on [in regard to safeguarding people's right to privacy]." Another relative told us about how caring staff were and said, "Oh definitely yes. When [relative] is stressed and they talk with him which eases the stress and they talk to me as well which is a good thing which is very, very useful."

Staff supported people in making day to day decisions about their care and all knew that they had a folder with their care plan in it and that staff wrote down the support they provided at each visit. People and their family members told us that staff talked with them and discussed how people liked things to be done. The member of the care staff team that contacted us said, "Yes, we are encouraged to treat the people in our care with decency, respect, care and most importantly, empathy. In short, like we would like to be treated."

People's individual care plans included information about people's cultural and religious heritage, daily activities, communication and guidance about how personal care should be provided. Everyone using the service at present was of white British heritage. Those who chose to adhere to a religious faith were Christian and the manager stated that staff were matched to people if they had this same religious belief. No one who we contacted raised any concerns about their heritage or beliefs being ignored or disrespected.

The provider had clear policies in relation to the right of people to have their diverse characteristics respected. People told us, "Oh yeah, definitely they certainly hear me as well", "'Oh definitely yes." and "Yes they do." It was evident that people felt that they were treated with dignity and were respected and cared about by the agency and care staff.

Good

Is the service responsive?

Our findings

Care plans were person centred and included people's likes and dislikes and the way they wished to be cared for. Information contained within care plans was specific to the type of support they required. For example, if people needed help to wash and dress this was included with details of how staff should do this in the way that people preferred. Some people needed support to take medicines or have a light meal. Staff were given guidance about how this should be done.

Care plans were specific to the agreed care that staff were required to provide in line with the initial assessment of care needs. The service had a daily log recording the care provided to people at each visit. The registered manager told us that log sheets were always held in the person's home and the older log sheets were returned by care staff at regular intervals for review and filing on each person's central care records. We saw that this was happening.

A person using the service told us that if there was a problem they would "Possibly talk with my social worker. I would talk to the manager or I would talk to [care co-ordinator] if there is something I could not talk to the manager about." This person did not say that this had ever been an issue.

A relative told us that the service was flexible and said "I can think of one occasion they put on a dinner and they accommodated me beautifully as I was out at work which was fine for me." Another relative told us "First of all if there was a problem I would speak directly to the care workers. I have spoken to the manager and she has insisted that I also contact her directly [if there was a problem]."

The care worker that contacted us said, "Yes [we are responsive], and to immediately ask for guidance from our supervisor or manager if we cannot efficiently deal with something by ourselves."

The service monitored the care provided to people through two monthly spot checks. The registered manager told us these checks would be increased for anyone whose care needs changed or if any concern arose.

People and relatives were provided with information on how to make a complaint when they began using the service. From the feedback that we received from people using the service it was evident that people felt confident about raising any concerns if they felt the need to.

The service did not specialise in providing end of life care although the registered manager said this would be carefully considered if requested. The service had, as a part of their policy and procedure documentation, a detailed end of life care guidance and procedure for all staff.

Good

Is the service well-led?

Our findings

At the time of our inspection, the service had a registered manager. The registered manager had appropriate training and experience to manage the regulated activity.

The service provided care and support that was of a good standard and people were usually happy with it, but evidently felt able to raise anything they were not happy with.

A person using the service told us when asked about how well the agency was managed said, "The manager has been out randomly and asked me how things are going. I feel happy to talk to the care workers and the manager about anything." and "I think she is a pretty good manager she stands no nonsense."
A relative told us, "I think they [concerns] would be taken seriously. This care agency do care. It can't be easy for them to fit all the clients in."

There were systems in place to monitor the service. For example, the manager and care co-ordinator carried out audits across a range of areas. These included medicines, care plans, spot check visits and monitoring staff training and staff performance. This demonstrated that the provider had good governance procedures in place and acted upon the findings of their monitoring procedures, for example, responding to changes in the care provided for people and the effectiveness of support packages.

People using the service were asked about their views. Apart from the small number of people who had used the service when it first commenced, the rest had been using the service for less than a year and had not been sent survey questionnaires to date. The registered manager showed us four survey questionnaires that had already been returned to the agency by people using the service for the longer period of time and these showed a good deal of satisfaction with the service. People told us, "Yes we did ask me quite a while ago, yes but there wasn't anything to worry about." and "I don't take things lying down I would be amazed if they ignored it [referring to any views that they gave]."

The care worker that contacted us said "The service is well managed, with a policy based on transparency and respect. Ours and the client's needs are well looked after and the responses to our problems or queries are immediate."

The care co-ordinator and registered manager were responsible for carrying out regular monitoring of care for people at home. It was evident from the care and other records that people were in regular contact with the agency and that views about their day to day care were obtained. One person did make a suggestion for changes that had been acted upon. The comments that people made demonstrated that they felt able to contact the agency and they received a response. This demonstrated that the service was open and encouraged people to freely share their views and responded to people's views.

The service had appropriate, up to date policies and procedures in place which were available to staff guide on various areas of their work. The policies we viewed included, safeguarding people from abuse, equal opportunity, medicines management and complaints. These policies had been introduced when the agency

was first registered and were not due for further review at present. The policies were appropriately detailed for a service of this type and were well written and clear so that staff knew what was expected of them and what they needed to do.