JP4Life Ltd

Prolife Healthcare Services

Inspection report

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Date of inspection visit:
06 October 2016
07 October 2016

Date of publication:
01 November 2016

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 was an announced inspection that took place on the 6 and 7 October 2016. The registered manager was not in the office during the inspection; we spoke with them by telephone on the 7 October. This was the first inspection after the service registered with the Care Quality Commission in April 2014.

Prolife Healthcare Services is registered to provide personal care to people in their own homes.
At the time of the inspection the service was providing personal care support for 23 people.

The service had a registered manager in place. 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. We also spoke with the nominated individual who was a director of the service. A nominated individual is a person employed as a director, manager or secretary of an organisation with responsibility for supervising the management of the regulated activity. The service had appointed a care co-ordinator in July 2016 to manage the rota, complete assessments and undertake quality spot checks on the service provided.

All the people we spoke with, and their relatives, said they felt safe supported by staff from Prolife Healthcare Services. Staff had received training in safeguarding vulnerable adults and knew the correct action to take if they suspected any abuse had occurred. Staff said the care co-ordinator, registered manager and nominated individual would listen to any concerns raised.

Where Prolife Healthcare Services had responsibility to administer people's medicines they were administered safely. Medication Administration Records (MAR) were correctly completed and checked by the registered manager; however these checks were not recorded.

The service was working within the principles of the Mental Capacity Act (2005) (MCA). The local authority social workers assessed people's needs and gained consent or completed best interest decisions for the support required before Prolife Healthcare Services were engaged to provide the support. People and their families, where appropriate, were involved in agreeing the support to be provided by the service.

Care plans and risk assessments were in place for each person who used the service. These gave guidance to staff on how to support people and mitigate the identified risks. The plans were reviewed every six months. A re-assessment was completed when people were discharged from hospital to record any changes in their needs.

A robust system of recruiting and training staff was in place. Staff completed mandatory training courses and undertook two shifts shadowing the care co-ordinator or registered manager before being placed on the rota. Training was refreshed on an annual basis.

Spot checks were completed by the care co-ordinator, registered manager or nominated individual every three months to observe staff practice. Supervisions were due to take place every six months; however we saw that this timescale was not always met. The care co-ordinator had started to complete supervisions with staff as well as the registered manager so these should be able to be held on a regular basis. Staff told us they felt well supported by the care co-ordinator and registered manager and they were always available by telephone if staff needed guidance or had a concern. This meant the staff had the skills, knowledge and support to provide effective care.

People who used the service and their relatives were complimentary about the staff at Prolife Healthcare Services. Staff had a clear understanding of people's needs. Staff could explain how they delivered person centred care and respected people's dignity and privacy. Staff supported people with their nutritional and health needs where applicable.

The care co-ordinator and registered manager checked all paperwork was in place and current when they completed the staff spot checks. Telephone monitoring calls were made to people who used the service or their relatives every two to three months.

There was a system in place to record, investigate and learn from complaints. Incidents and accidents were recorded and reviewed to reduce the likelihood of the incident reoccurring.

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 who used the service and their relatives told us they felt safe with the staff that supported them. Risk assessments were in place to guide staff how to mitigate the identified risks.

A robust recruitment system was in place to ensure suitable staff were employed. Staff had received training in safeguarding adults and knew the correct action to take to report any concerns.

Where the service had responsibility for administering medicines they were administered safely.

Is the service effective?

Good

The service was effective.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA).

Staff had received the induction and training they required to carry out their roles effectively. Regular spot checks of staff were completed. Staff had supervisions, however these were not always held regularly.

We saw that people's health needs were met. Where it was part of the support provided by the service, we saw that people's nutritional needs were met.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were kind and caring.

Staff we spoke with showed that they knew the people they were supporting well and had a clear understanding of privacy, dignity and respect.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they started using Prolife Healthcare Services and were written in a person centred way with the involvement of people and their relatives.

Staff were introduced to the people they would be supporting or given a thorough verbal handover of the person's needs before they started to support them.

A complaints procedure was in place. People told us that issues were dealt with informally by the service. Formal complaints were fully documented.

Is the service well-led?

Good

The service was well-led.

The service had a manager who was registered with the Care Quality Commission.

People who used the service, relatives and staff told us that the care co-ordinator, registered manager and nominated individual were approachable and would act on any concerns that they raised. Staff said they enjoyed working in the service.

Quality assurance systems were in place to check the relevant paperwork was in place and to gather the views of people who used the service and their relatives.

Prolife Healthcare Services

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 and 7 October 2016. The inspection was announced as Prolife Healthcare Services is a small domiciliary care organisation and we needed to make sure someone was available to talk with us. The inspection was undertaken by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.
We contacted the local authority commissioning team, the local Healthwatch board and spoke with two social workers. No one raised any concerns about Prolife Healthcare Services.

With their permission we visited two people who used the service. We spoke by telephone with one relative and one person who used the service. We spoke with five members of staff and the nominated individual. We spoke with the registered manager by telephone on the second day of the inspection.

We looked at records relating to the service, including four care records, two staff recruitment files, daily record notes, medication administration records (MAR), policies and procedures and quality assurance records.

This was the first inspection for Prolife Healthcare Services.

Good

Is the service safe?

Our findings

All the people and relatives we spoke with said they felt safe when supported by Prolife Healthcare Services staff. One relative told us, "[Name] is safe with the staff; they know what they are doing."

The training records we reviewed showed staff had received training in safeguarding vulnerable adults. This was confirmed by the staff we spoke with. Staff were clearly able to explain the correct action they would take if they witnessed or suspected any abuse taking place. They were confident any issues they raised would be dealt with by the care co-ordinator, registered manager or nominated individual. This should help ensure that the people who used the service were protected from abuse.

We looked at the recruitment files for two members of staff, one of whom had recently been recruited. We found they contained application forms with full employment histories, two references from previous employers and showed appropriate checks had been made with the disclosure and barring service (DBS). The DBS checks to ensure that the person is suitable to work with vulnerable people. This meant the people who used the service were protected from the risks of unsuitable staff being recruited.

We discussed staffing with the nominated individual and care co-ordinator. Staffing levels varied depending on the needs of the people who were being supported. People received support from the same support worker, or a small team of support workers to provide consistency. The service did not use agency staff, with any cover needed when staff were off sick or on annual leave being organised within the staff team. If required the care co-ordinator, registered manager or nominated individual would complete the support visits. This was confirmed by the people and relatives we spoke with. An on call system was in place if staff needed advice or support outside of office hours.

People who used the service told us the staff attended at the agreed visit times, with a little variability due to traffic delays, especially in the morning. One relative said, "If they are running late the office will phone. They always stay and complete all the agreed tasks even when they arrive a little late." They also said support visits were not missed by the service. One person said, "On one occasion there was a problem with the carer so the manager came to complete the call." However, one person said that staff always attended but the timing of the tea time call could be varied. They did state they were happy with the support provided by Prolife Healthcare Services.

The care co-ordinator showed us the 'Care Planner' computer system used to schedule the visits required each day. This showed a short amount of travel time was allowed (usually five minutes) on the rota between calls. We were told the calls were arranged in 'runs' with visits close together to reduce the travel time for staff. The service had four separate runs at the time of our inspection. The staff we spoke with confirmed this and said the travel times was usually sufficient as the calls were close together.

When staff arrived at a visit they had to log into the 'care planner system' via an app on their phone and a fob kept in each person's care file. If the staff were 15 minutes late for a call the care planner system alerted the care co-ordinator at the office. They said they would then contact the staff member to identify if there

was a problem and contact the person who used the service to let them know the staff member was running late.

We saw the care files included information about the risks the people who used the service may experience, for example infection control and personal care. This included guidance for staff and any control measures in place to manage the risks. Where appropriate a manual handling risk assessment was completed. This contained clear guidance for staff to follow in order to transfer or support people to mobilise or turn safely. We saw an environmental risk assessment was completed for each property the staff visited. The risk assessments were regularly reviewed and updated when people's needs changed.

We looked at how medicines were managed by the service. We saw staff had received annual training in the administration of medicines. Staff were observed administering medicines during their induction and during spot check visits carried out by the care co-ordinator, registered manager or nominated individual. Each person had a medicines management agreement which detailed who was responsible for administering and re-ordering any medication required. In some cases the family administered the medication; this was clearly identified in the care plan.

Where Prolife Healthcare staff administered medicines there was a Medicine Administration Record (MAR) in place. We saw these were fully completed. We noted staff also signed the daily log sheet to state the medicines had been administered. The MAR did not contain details of each individual medicine prescribed and referred to the 'blister pack.' The prescribed medicines contained in the blister pack were printed on the blister pack by the pharmacist. We saw any short course medicines prescribed were added to the MAR sheet by staff. We were told people were able to inform staff if they needed any 'as required' medicine, such as pain relief. Staff said they would contact the care co-ordinator or registered manager to check before administering 'as required' medicines.

We saw it was noted in the care plan for one person the GP had agreed for the tablet to be crushed as the person had difficulty in swallowing the tablet. However this was not evidenced in the file. The person knew the tablets were being crushed and consented to this. The Nominated Individual told us the tablets were being crushed before they started to support the person and so this information had been given to them by the social worker when completing the initial assessment. Good practice guidelines state there should be evidence of the GP's instructions in the persons care file.

Care plans contained details of any creams that were needed. Body maps indicated where the creams were to be applied. We saw a record of where patches were placed for one person. This meant the patch was not located in the same place each time, as per the prescribing instructions.

This meant medicines were safely managed by the service.

We observed staff used personal protective equipment (PPE) such as gloves and aprons as required. These were provided by the service, with a supply kept at each person's home. Staff were also given a stock of PPE in case additional were required on a visit. We saw from the training records that staff had received training in infection control.

We saw that incident and accident forms were completed when required and reviewed by the registered manager and nominated individual. Details of the incident and any actions taken were kept within the Care Planning system. The incident was also recorded in the person's daily logs.

The service had a business continuity plan in place in case of any emergency. This included all computer

records being stored remotely. The service would continue if the central office was not operational due to events such as a utility failure as the staff supported people in their own homes.

Good

Is the service effective?

Our findings

People received effective care and support from the staff at Prolife Healthcare Services. All the people we spoke with, and their relatives, said the staff knew them well and had the skills to support them effectively. The care co-ordinator, staff and people who used the service told us staff were introduced to people who used the service before they started to support them. People who used the service and family members told us, "I have regular cares; I know them all" and "They send the same people." A staff member told us, "I've never been to support anyone who I had not been introduced to first."

The Care Planning system recorded all the training staff had completed. Training undertaken included moving and handling, dementia awareness, first aid, health and safety and the role of the care worker. Training was refreshed annually. The Care Planning system alerted the care co-ordinator when staff were due to refresh their training. We saw all training was up to date.

The majority of training was completed via DVD's, with questionnaires used to check the staff had understood the course. Practical training for moving and handling was also used. All the staff we spoke with said they received regular training and were up to date with their training.

Staff told us they had completed all the mandatory training as part of their induction when they joined the service. They then completed two days of shadowing the care co-ordinator or registered manager; one day to observe the support each person required and the second day to be involved in the hands on support. This meant staff were introduced to the people they would be supporting, before being placed on the rota and had the skills and knowledge to support them effectively.

We saw the care co-ordinator and registered manager completed 'spot checks' with staff. They went unannounced to observe the staff member when they were completing a support visit. This was confirmed by the staff we spoke with. The spot checks were recorded and were an opportunity to discuss any issues with the staff member. Spot checks were completed every three months for each staff member. We saw staff also had supervisions with the registered manager or care co-ordinator. These were planned to be completed every six months; from the records we saw supervisions were not always held within these timescales. The care co-ordinator had started to complete staff supervisions as well as the registered manager so that supervisions could be regularly held.

All the staff we spoke with said they felt well supported by the service. One said, "The office phones most days to check if I am okay. I can also ring them if I have a question or issue." We were told there a manger was available on call when the office was closed. This meant the staff were supported to undertake their role.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The people supported by the service had been assessed as requiring support by the local authority social services. The social services either gained the consent of people for the support or completed the required best interest decision for support to be provided before Prolife Healthcare Services were engaged to provide the support. Staff received training on the MCA as part of their induction and annual refresher training. We saw in the care files that the people who used the service, or their relatives where appropriate, had agreed to the support tasks the staff would complete and had signed their consent.

We saw daily log sheets were completed for each visit. This meant staff could relay information to each other as required. We were told if there were any changes to a person's support the care co-ordinator or registered manager would phone the staff directly to inform them. The Care Planning System was also used to highlight any key tasks required to be completed at each visit. Staff could view this information via an app on their mobile phone. For example for one person the note on Care Planner was 'go for a walk with [Name] in the garden.'

The service did not routinely support people to attend medical appointments, with people or their families arranging the medical appointments. Staff monitored people's health and well-being when they provided support, for example checking people's skin integrity when providing personal care. Where required staff would contact the district nurse or GP. During the inspection we observed that an additional visit was arranged for one person to administer a short course medicine prescribed by the GP. A social worker told us the service had contacted the district nurse when they had seen there had been deterioration in the person's skin condition.

Care plans identified if people required support with preparing their meals. Details of any dietary requirements, for example if the person was a diabetic and needed support to maintain a suitable diet or needed soft food to aid swallowing. This meant people's health and nutritional needs were met by the service.

Good

Is the service caring?

Our findings

All the people and their relatives told us the staff were kind and caring. One person said, "The staff are very polite and friendly" and "The staff are very good; they will have a chat if I want to talk and will do extra things if I ask, like posting a letter." Another commented, "They have never sent anyone I didn't like; their choice of staff is very good" and "I said the bedsheets needed changing as [Name] wasn't well and they did it straight away." Three people told us the service provided by Prolife Healthcare Services was better than they had received when they had been supported by a previous agency.

All the staff we spoke with knew the needs of the people they supported. One said, "I am able to read people's care plans when I am introduced to them so I know what I need to do." We observed positive interactions between staff and the people who used the service. Staff spoke to people about the support they were going to provide.

Staff were able to describe how they gave people choice and maintained their privacy and dignity when providing support. One said, "I ask people if they want to do things for themselves and respect their wishes." Care plans included details of people's preferences, for example for staff to talk through the personal care routines each day. We saw care plans detailed how staff would gain access to people's property. For some people they were to knock on the door and wait to be let in and for others use a key kept in a key safe and announce their presence so the person was aware they had arrived. This should help ensure that people's privacy and dignity were respected.

We saw people kept their care records at their own homes. The file contained a service user guide which gave details about Prolife Healthcare Services and how to contact the service if people wanted more information, to make a complaint or request a change in their support. This meant people could check what was written in the files. A file was also kept securely at the service's office, along with other records relating to the running of the service, for example staff records. This protected the confidentiality of both the people who used the service and the staff.

We were told the service did not currently support any one who was at the end of their life. We saw the care files detailed any wishes people had made known for the care and support they wanted at the end of their life. For example one person wanted the emergency services to be contacted.

Good

Is the service responsive?

Our findings

The four care plans we viewed were written in a person centred way. The care co-ordinator, registered manager or nominated individual completed an initial assessment, using the local authority social service assessment and meeting with the person and their relatives as appropriate. We were told that wherever possible support was started with an afternoon visit. This gave the service time to read the information provided by the local authority. The care co-ordinator, registered manager or nominated individual would complete the first support visit and undertake the assessment at the same time. The assessment included relevant details about people's preferences, medical history, medicines, dietary requirements, mobility and how people communicated their needs. The assessments identified if the person who used the service had any preference over having male or female carers. This preference was then considered when allocating the support to one of the staff 'runs'. For example one run was completed by male staff. This meant if a person did not want male staff to support them they could not be allocated to this run.

An initial care plan was then written. Where ever possible the staff were introduced to the person who used the service by the person who completed the assessment. If this was not possible staff were verbally given all the required information before their first support visit. The care plans contained clear guidance for staff on the tasks to be undertaken on each visit. This included details of what the person, or their relatives, were able to complete themselves. We were told the care plans were reviewed after six weeks to check all the routines identified were as required. Reviews were then held every six months. The care plans we viewed had all been reviewed appropriately. We were told that a re-assessment of people's needs was completed when people were being discharged from hospital to ensure any changes in their needs were known before support was re-started. This meant the staff had up to date information about people's needs and the support tasks that were required.

Staff said they contacted the office if they noticed a change in a person's needs. They would also inform the office if they regularly needed more time than allocated to complete the specified tasks. The care co-ordinator said they would monitor the calls to ensure the additional time was required each day and they would do a spot check to ensure the staff member was following the agreed care plan. They would then liaise with the person's social worker to request additional time for the support visit. This meant staff would have the time to provide the agreed support at each support visit.

The service had a complaints policy in place. People we spoke with said they would contact the office if there was a problem. One person said, "I had some difficulty a while ago where a new staff was not aware of what they should do. I spoke to the office and it was sorted out." The care co-ordinator told us when a person who used the service raised a concern they would complete additional spot checks to ensure the staff were completing the required tasks properly.

We saw the service had received a complaint from a person who used the service. We saw this had been fully documented and the nominated individual had met with the person. A social worker we spoke with said the care co-ordinator had taken action on the complaint as requested. However the social worker said the person felt their initial issues had not been fully addressed until they made a formal complaint. The issue

had been resolved at the time of our inspection.

Another social worker we spoke with said the service had been very flexible to accommodate the needs of one person. They had acted appropriately to the feedback provided and had been very willing to work with the local authority to ensure the service provided met the needs and preferences of the person who used the service.

This meant the service acted on issues and complaints raised with them.

Good

Is the service well-led?

Our findings

The service had a registered manager in post as required by their registration with the Care Quality Commission (CQC). The registered manager was not present in the office during our inspection. We spoke with them by telephone at the end of the inspection. The care co-ordinated and nominated individual were very 'hands on' within the service. People and their relatives told us they received phone calls and visits from them on a regular basis.

People who used the service, their relatives and staff told us the office staff were approachable if they had any issues or concerns. One staff member said, "I feel very much supported by the office staff; I can phone them about any concerns I may have." The staff we spoke with said they enjoyed working for the service. One said, "I love it; I'm really well supported (by the office staff)."

The service had a number of quality monitoring tools in place. We were told by people and their relatives that they received phone calls from the registered manager or care co-ordinator every two to three months to ask if they are happy with the service and if there are any changes in the support required. We saw records of the phone calls made in people's care files. A comment noted during a telephone monitoring call was 'communication with the office is good.' People also said the registered manager, care co-ordinator or nominated individual also cover for staff when they are off and ask whether they are happy with the service provided whilst they are there. As previously mentioned in the report spot checks to observe staff practice are also completed and people are asked about the service they received when these take place. This meant the service sought the views of people who used the service and their relatives.

The nominated individual told us they would collate the feedback forms together in future so they could identify any possible trends in the responses.

During the spot checks the registered manager, care co-ordinator or nominated individual checked the care files in people's home. The completed Medication Administration Records (MAR) were returned to the office and the registered manager checked that they had been fully completed. However we did not see that this check had been recorded.

We saw a quality monitoring spreadsheet by the nominated individual. This was a monthly check that the relevant care plans and risk assessments were in place and had been reviewed. Quality monitoring telephone calls and visits to people who used the service were recorded to monitor they were taking place. This meant the service had systems in place to monitor the quality of the service they provided.

We were told that staff meetings were not currently held. Due to the small nature of the service they did not have the capacity to release staff from their support duties to attend a staff meeting. Staff said they were in regular contact with the care co-ordinator, by telephone and when they completed the spot checks and could raise any issues they wished with them.

The nominated individual told us they were looking to increase the number of people they supported. They

are looking to develop new support runs in neighbouring areas to where they currently operate. This would allow staff to be flexible across the runs as they were close together. The service does not accept new support packages unless they can fit into one of the runs they have so there is not too much travelling required between support calls.

We saw the service had an up to date set of policies and procedures in place to guide staff.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the Care Quality Commission (CQC). We checked the records at the service and found that all incidents had been recorded, investigated and reported correctly.