Totally Living Care Limited

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We undertook an announced inspection of Totally Living Care Ltd. on 27 February and 5 March 2018.

Totally Living Care Ltd is a domiciliary care service providing personal care for people in their own homes in the Salisbury area. It provides a service to older adults and younger people with disabilities. At the time of our inspection 49 people were being supported by the service.

At the last inspection we found a breach in Regulation 12 of the Health and Social Care Act 2014, safe care and treatment. Risks to people's personal safety had not always been assessed or plans put in place to manage these risks effectively and safely. At the last inspection on 10 and 11 January 2017, we asked the provider to take action to make improvements to people's risk assessments and this action had been completed.

At this inspection we found that improvements had been made. Risk assessments were in place and specific risks to people's personal safety had been identified; however the guidance and actions on how to manage the risks were inconsistent.

There was a registered manager in post and a service co-director who were jointly managing the service. 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.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and were able to apply the principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. We observed that improvements had been made in gaining the appropriate consent to receive the care provided by the service; however documented mental capacity assessments were not always in place where people lacked the capacity to make decisions about their care.

People's medicines were managed and administered safely and recorded appropriately. Robust monitoring checks were in place which included external and internal audits of medicines administration records (MAR charts) and any changes to people's prescribed medicines were added to their charts weekly.

Staff benefitted from comprehensive regular training and materials to support their learning styles. Staff received an induction period, which included competency checks, observation and regular one to one supervision.

People told us they were well looked after and had good relationships with staff. There were sufficient staff to meet people's needs and people received their care when they expected to and according to their care schedule. The service had safe recruitment processes in place.

People were safe and staff understood their responsibilities in relation to safeguarding and whistleblowing. The service had systems and information in place to instruct staff on how to notify the appropriate authorities.

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 mostly safe.

Risk assessments to keep people safe were in place, but they required more consistent detail and information on how to manage those risks.

People's medicines were managed and administered safely and people received their medicines as prescribed.

People told us they felt safe and staff knew how to identify potential abuse and raise concerns appropriately.

Is the service effective?

Requires Improvement

The service was mostly effective.

Although risk assessments were in place, where people lacked the capacity to make decisions about their care, documented mental capacity assessments were not in place.

People's consent was gained before commencing their care.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further development.

Is the service caring?

Good

The service was caring.

People and relatives gave us positive feedback about the staff and told us they were caring.

The service promoted people's independence.

Staff spoke compassionately and respectfully about the people they provided care for.

Is the service responsive?

Good

The service was responsive.

Care plans detailed daily routines specific to each person.

People received regular reviews of their care plans and the service was responsive in implementing the changes required.

People, relatives and staff knew how they could make a complaint or raise a concern.

Processes were in place to support people with their end of life care needs.

Is the service well-led?

Good

The service was well led.

The service had received good feedback from people, relatives, staff and professionals.

There was an open, transparent and supportive culture and the views of people and their families were welcomed.

The managers were passionate about the service they provided and were continuously looking at ways to improve.

Totally Living Care Ltd

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 27 February and 5 March 2018 and was announced. We gave the provider two days' notice of our visit. This was because the registered manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that someone would be in. The inspection was carried out by one inspector.

Before the inspection we looked at information we held about the service. This included previous inspection reports and notifications we had received. Notifications are certain events that providers are required by law to tell us about.

We spoke with five people and relatives who use the service, three care staff, two administrators, two senior care staff, the co-director and the registered manager. During the inspection we looked at five people's care plans, four staff files, medicine records and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people's personal safety had not always been assessed or plans put in place to manage these risks effectively and safely. The provider wrote to us with a plan of what actions they would take to make the necessary improvements. At this inspection we found that some improvements had been made. Risk assessments were in place and specific risks to people's personal safety had been identified - however the guidance and actions on how to manage the risks were inconsistently recorded and variable in the level of detail.

The service had developed a new and comprehensive care and risk assessment document, which identified potential areas of risk in each area of care being provided. For example mental health, medicines, eating and drinking, mobility, skin integrity and the use of equipment. The document was used as a monitoring tool to reduce any identified risks. However, the new documents were not yet in place for everyone.

Each person had a 'domiciliary home risk assessment', which checked the safety of a person's home environment. However, for some assessments where a hazard was identified, no actions were recorded in order to manage or minimise the risk. For example where it was recorded that flooring was not in a good condition and free from trip hazards.

Where risks to people's health and safety had been identified, associated individual risk assessments were in place. One person had a risk assessment which identified a risk of falls. The action to manage the risk was and stated 'support, monitor and encourage use of mobility aids.'
Another person had a manual handling risk assessment, which stated the movements the person was able to do independently and what support and equipment they required to manage these safely.

One person had a risk assessment which identified a risk around swallowing. The risk assessment detailed that the person was at risk of choking and required a pureed meal. The registered manager had identified that the carer was required to remain with the person whilst they ate their meal and complete daily dietary charts. This was in line with guidance from a speech and language therapist assessment (SALT).

Medicines administration, management and disposal was provided safely. The service had a new medicines policy and protocol in place. Medicines risk assessments were in place for each person and detailed whether the person was able to manage their medicines independently or if they required support. For example for one person their risk assessment had identified allergies. The person was assessed as requiring full assistance of their medicines management.

Medicines administration records (MARs) had been re-developed which clearly identified the medicine to be taken as prescribed. The registered manager monitored the MARs weekly and any required changes were added. A spread sheet of monthly MARs clearly showed where there were any issues, such as missed signatures, which the registered manager investigated and took appropriate action. An external professional also audited the MARs weekly. The registered manager said they "can see the difference in the MAR sheets, it

has been tightened up and it now all marries up and the outcomes and actions are all in control."

Staff were trained in medicines administration practices and had a good understanding of the needs of the people they provided care for. For example one person told us, "I take my own medication but I like to check in the mornings with my carer there, and if things are not quite right I can rely on them to take the appropriate action." Staff were observed and assessed in their competency before they undertook medicine administration unsupervised.

People told us they felt safe. One person said, "They [staff] make me feel safe, they [staff] turn up when they say they will, absolutely fine not a problem" and a relative told us that they "have no concerns at all." The staff we spoke with were trained and could explain how they would recognise abuse and what they would do about it. One staff member told us, "If I see anything untoward I won't feel shy I will go to a senior straight away." We observed several posters of the Wiltshire Adult Safeguarding Board flowchart. Staff were also confident in their knowledge about their responsibility to whistle blow and a staff member told us that they would "report it to CQC". Staff felt able to approach senior staff and the management team with any concerns and one staff member said they had, "100% confidence that something would be done."

Records related to staff recruitment showed a safe process was followed. We observed pre-employment checks were in place including references, identity checks and DBS. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Each staff member had an employment pack which detailed the services' ethos of care and all policies relating to the provision of care, including lone worker hazard and disciplinary procedures. There were sufficient numbers of staff deployed to meet people's needs. Staffing rotas confirmed this. One person we spoke with told us "They [staff] are very reliable" and a relative said, "They [staff] send us a list each week so we know who is coming and what time or if something has changed."

People were protected from the risks associated with infection control. The manager told us that all staff had a supply of PPE (personal protective equipment) in their cars and there is an open supply in the office. We observed staff using this. The service undertook safe practices such as using an encrypted messaging service for the carers. The staff knew what to do if an incident occurred such as, unable to gain entry to a property. One staff member told us, "If I couldn't gain entry I would phone the office or a senior immediately followed by the [person's] house number and the next of kin."

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found that the skills and training of staff required improvement and that people and relatives had expressed their concerns around the lack of experience of the staff. At this inspection we found that improvements had been made.

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. The service had developed a colour coded matrix to clearly show where training had been completed and when the refresher course was due for each member of staff. Staff training followed the care certificate and included e-learning modules, booklet completion and in-house face to face training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life consisting of the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff told us they received an induction of three days a week for two weeks. They also received mentoring, a period of shadowing in the field and were assessed for competencies before they were signed off to work independently. Staff were complimentary about the level of training and induction. One staff member said "I feel more prepared, if there is anything I don't know I can look at the booklet or ask in the office." Comments from people included, "[My carer] is very au fait with my medical condition and my needs. She is very alert, she knows me so well that she can look at me and know if I am having a good or a bad day" and "She [staff] arrived one morning to find me in a collapsed state, her actions were very swift and appropriate. She got in touch with the office and stayed with me until the ambulance came." A relative commented, "Oh yes, I am very impressed with them."

In addition to the provider's mandatory training, we observed a notice board of information and guidance for staff, which highlighted a different theme of care skills each month. Staff told us they found this interesting and looked forward to each new topic. An in-house learning booklet accompanied each monthly topic, the most recent version being communication and recording. This gave staff guidance on areas such as 'the principles of good record keeping' and highlighting the different types of communication people may use such as British Sign Language (BSL), Makaton and face and body language. The booklets were bright, informative and used visual imagery, which staff told us was appealing and enabled staff to learn in a variety of ways. A staff member told us "Some staff learn visually, some staff learn 'hands on', we [staff] try to make it work for everyone" and another staff member said, "the training is brilliant." Guidance and information were located around the office for staff to read informally.

A supervision matrix was in place, which detailed when staff received supervision, either in group meetings, one to ones, appraisal or observation. The matrix also detailed where a staff member received additional supervision due to a learning need. Senior staff completed spot checks, which identified if staff were wearing their uniform and ID, whether they had full PPE and if they washed their hands. The spot checks highlighted good practice for example, a staff member had noticed that the care plan did not contain information about the person crushing their medicines when taking them. The staff member documented this and fed back via the on-call number to update the care plan.

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 MCA. For people receiving care in their own home, this is as an Order from the Court of Protection.

The service sought people's consent. We observed signed consent forms in people's care plans, which covered the assessment and care planning process and the date for the care plan to be reviewed. However, there was no recorded evidence of any mental capacity assessments in place in some of the care and support plans observed. For example one person who lacked capacity, had a risk assessment for medicines administration and was assessed as 'not being able to understand their medicines fully and 'gets very anxious' and is 'at risk of overdose', if their medications were not managed. A secure cupboard was used in the person's house to store the medicines which were administered by the staff member. Although these details were documented in the risk assessment, there was no recorded evidence of a best interest decision.

Staff, were knowledgeable about the Mental Capacity Act and were able to tell us that in practice they always asked permission and assumed capacity in the first instance, one staff member said, "It's about them having choices and being able to make their own decisions about things."

People's needs and choices were documented. One care plan stated I have capacity and have choice in what I want, ask me' another stated, 'I would like a shower on Monday, Wednesday and Friday and a full body wash on the other days.' People's needs were assessed prior to accessing the service to ensure those needs could be met and there was evidence that people and their relatives had been involved in the assessment and care planning process. The service uses a 'simple care plan' which is left in the person's home, it briefly details the person's daily routines and the support which is required.

The service was working closely with other professionals to ensure people were supported to maintain good health. For example, one care plan stated that a small broken area of skin was noticed for one person and the community nurse was called, later recordings showed that the area was healing. The service provided care to a person who required particular methods to support their behaviour. This person experienced anxiety and repetitive behaviours. The provider had felt that the local health professionals were not supporting them to support the person effectively. Following improved communication, they had since developed a collaborative working relationship and the person was monitored by health professionals every eight weeks. The provider ensured that only a small number of carers visited regularly to ensure the person always had someone they knew.

Concerns and complaints were managed appropriately. We saw a letter of concern from a person who uses the service. It requested that the times of the visits as detailed in the care and support plan were respected, as the person said they felt they had little control over their lives (due to their medical condition). This was discussed at the staff meeting and times of visits re-iterated to staff who provided support for this person.

Where people approached the end of their life the service worked alongside healthcare professionals, the person and their relatives, to provide compassionate and dignified care. The care plan instructed staff on how to enable the person to maintain independence for as long as they felt possible. For example, the person was able to use the stairs and wanted supervision only. The care plan stated 'Allow as much independence as possible, comfort and minimise pain at all times and support gently.' There was evidence that the plan had been made with the person as their comments on what assistance and how they wanted

to receive this was documented, 'just observe me please.' Instructions to staff included the person's wishes to be able to talk openly about their life and death. Feedback received from the relative of one person who had received end of life care, was positive and complimentary, "You have all treated [my relative] with respect and dignity, thank you for your endless patience and kindness."

Good

Is the service caring?

Our findings

People told us the service was caring. Comments included, "They're [staff] friends now and I look forward to seeing them" and "In the main they are very good and on the whole I am very well looked after." Another person said they had, "Pretty much the same carers, it's consistent." Comments from relatives included, "They are very good", "All very pleasant" and "They always have a nice chat to [my loved one], and very respectful."

The registered manager told us that they or a senior staff member visited a new person initially. They aimed to maintain continuity of care for the person and the staff member. A new staff member told us that they loved their role. When they were allocated a new person to care for, the first thing they did was to go through the care plan to gain information about the person. People had a choice of whether they preferred a male or a female to provide their care and there was evidence of what the person liked to be called. Daily care logs showed kind interactions and respectful use of language, for example '[person] still suffering with a cold, was dozing so woke gently, lovely chat'; '[person] declined a shower, made comfy in bed' and '[person] fancied fish and chips today so I went to chip shop and got [person] fish and chips.'

We observed many compliments, thank you cards and letters from people, for example, "I thought you were wonderful. I did wonder what I was going to do. I felt very cared for, not forgotten, my grateful thanks for the care I received" and "I just wanted to let you all know just how much I appreciate everything that you all do for me, if it wasn't for you all I'm not sure how I would cope." Relatives had also sent many compliment cards, letters and telephone messages, some examples were, "You had such a special rapport with [my relative]. I will always be so very grateful for your wonderful care of [my relative]" and "I don't know how I would have managed without your support." We observed kind and compassionate interactions between staff and people and their relatives who visited the office.

People's dignity and privacy were respected. One person told us, "They do definitely treat me with dignity and respect, the way they talk to me and help me." People's daily care logs showed that they were supported to maintain independence, for example it stated 'all personal care to be given in encouragement of [person] doing as much as [they] can for[themselves], 'greet [person] and check how [they] are today' and '[person] shaved himself today.' Relatives said, "[my loved one] has reported to me that they are kind" and "Several of them seem to have developed a good rapport with [my loved one]." Staff rotas identified visits, times and the type of care required by the person. They were clear and informative. People were sent a similar rota.

The service recognised the different needs of their staff group and promoted their development. They provided local visits for staff who do not drive and needed to walk to their visits. They had two members of staff whose first language was not English but had been working in care for five years and had completed accredited qualifications. The service promoted 'carer of the month' for staff, who were given votes from the whole staff group to recognise quality, commitment and good practice. A new staff member said "I feel I can progress if I want to."

Good

Is the service responsive?

Our findings

At the time of our inspection, the area was due to have severe weather conditions forecast for the following few days. The service had put together a contingency plan in order to maintain service provision to the most vulnerable people. The weather conditions meant that staff needed to visit people on foot. They had devised a planned timetable between staff who lived near each other and closest to people. For people who required two staff to assist them the service had prioritised the directors 4x4 vehicle to guarantee the visit. They had a communication plan in place to keep in contact with people to reduce anxiety and gave reassurances. All staff had been asked to carry out checks on their current visits to ensure people had fully stocked fridges and their homes were warm in preparation. The registered manager also contacted services such as Lifeline to let them know of the contingency plan and other providers in the locality to see if they could assist or work together to undertake visits.

Following the period of bad weather, there were complimentary phone calls and comments "I just want to thank the office and the carers were exceptional." The registered manager said, "It is lovely for them to see there is not an I in the team and see that we all work together." A senior staff member told us when Salisbury experienced power cuts recently, the staff team undertook a similar contingency plan. Walking to people's homes, prioritising the most vulnerable and ensuring people had torches and were warm and safe until daylight.

People were assessed to ensure their support plans met their individual and changing needs. Comments from people included, "[Staff] picks up on things, notices things", "The [staff] are very good at telling me when I should see the doctor if my condition is changing" and "They [staff] will contact my daughter to let her know." A relative told us, "The carers have raised a few things very quickly." A staff member said, "The care plans are a working document and we constantly update them if something changes." We observed a schedule which showed a review of care plans every two weeks for a particular topic. At the time of the inspection the topic was to review DNAR (do not attempt resuscitation orders) and TEPs (treatment and escalation plans) to ensure these details were in place.

People were kept informed of who would be visiting them and at what times. They each received a weekly 'client visit sheet' and were contacted by telephone if there were any changes to be made. Staff were informed of changes via an encrypted mobile messaging service and would make changes to the person's copy of the rota. One person told us, "If there are any changes they will ring me." A relative commented "They [staff] are able to change things around for [my loved one] when they needed an appointment" and "They [staff] stay longer than scheduled if required." The service had an on call rota, which was split between senior carers and a backup person. There was always someone available for people and staff.

People and their relatives had been involved in the creation and reviews of their care plans. Elements of the care plan included the following sections, 'to improve my health and well being', to improve my quality of life and make a positive contribution' and 'I'd like to maintain my personal dignity and respect'. The service was also developing a 'life history' section to compliment the care plan. One person was supported to remain in their own home and to be as independent as possible. They liked to knit gloves for all the staff.

People's diverse needs were respected. Where people had a visual impairment measures were put in place to assist in communication, for example the use of a large print diary close to where the person sat. The diary detailed the times of visits and which staff would be coming. Another person was not able to communicate verbally and used pictorial communication cards and letter boards. The care plan stated, 'I use picture cards to indicate what I want. Please use my prompt cards to help with communicating what I would like, or I will show you [using my wheelchair]'. The pictures detailed general daily living items such as the TV, remote, bed, chair and table. Pictograms were used which asked questions such as 'where is your pain today?', how bad the pain was and if the person wanted the window open or closed. We observed in one person's care plan guidance on how to assist them to remain independent whilst respecting their particular disability. The person had limited use of their arms but was able to clean their own teeth using an electric toothbrush placed between their knees. The care plan stated "I will sit on the stool, place a little amount of toothpaste into my mouth."

Concerns and complaints were managed appropriately. We saw a letter of concern from a person who uses the service. It requested that the times of the visits as detailed in the care and support plan were respected, as the person said they felt they had little control over their lives (due to their medical condition). This was discussed at the staff meeting and times of visits re-iterated to staff who provided support for this person.

Where people approached the end of their life the service worked alongside healthcare professionals, the person and their relatives, to provide compassionate and dignified care. The care plan instructed staff on how to enable the person to maintain independence for as long as they felt possible. For example, the person was able to use the stairs and wanted supervision only. The care plan stated 'allow as much independence as possible, comfort and minimise pain at all times and support gently.' There was evidence that the plan had been made with the person as their comments on what assistance and how they wanted to receive this was documented, 'just observe me please.' Instructions to staff included the person's wishes to be able to talk openly about their life and death. Feedback received from the relative of one person who had received end of life care, was positive and complimentary, "You have all treated [my relative] with respect and dignity, thank you for your endless patience and kindness."

Good

Is the service well-led?

Our findings

There was a registered manager in post. 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. The registered manager managed the service, jointly with a co-director. Both shared similar visions for the service and how it should develop. They said "We have the same views on how we want the company to evolve." They both regularly worked alongside the staff undertaking care visits, which had enabled them to know the people using the service. They were both positive role models for the staff team.

The registered manager and co-director had made significant efforts to improve the quality of their auditing and quality assurance processes to enable them to provide a high standard of care. They were both passionate about the company and its continued development. Following the last inspection new processes had been developed around training and staff development, risk assessments and medicines administration. For example, the service had made significant changes to their medicines management following a safeguarding incident. A health professional now completed an external audit every four weeks. Staff who made a medicines error, received a letter of concern. After three letters of concern they received a written warning and had one to one supervision and refresher training. The method used was to give the staff member scenarios and ask them what they would do. Recording was kept in the staff disciplinary file for audit purposes. They strived to continually improve and welcomed feedback from professionals, staff and people. The co-director said, "We continually reflect and ask how can we improve our services?"

The service requested feedback from people, their relatives and staff. A comment from the 2017/2018 client survey stated "Everything is fine" and we saw the rating for staff was 'excellent' and for daily care 'good'. The 2018 staff survey included aspirations and potential development opportunities. Some of the suggestions included asking for personal input from a staff member who is familiar with the location and the person; a suggestions box for people to write down and air their views, rather than face to face. The service conducted regular quality assurance checks on people's care plans to monitor the care provided. Spot checks were carried out to observe staff conduct in people's homes.

The service worked closely with other provider agencies such as, Wiltshire Council, Alzheimer's Alliance and Dementia Friends. The service put out a local plea for Christmas decorations via social media and received many donations to decorate people's homes. The main office was on the high street and they had many visitors from local people and signposted people to other services relevant to their needs. The registered manager and co-director stated that their intention was to be known as the 'on street care company'. The co-director said "It is often like a drop in centre, people pop in for a coffee." They were also members of the Fisherton Street Association, joined in with open days for the public and hosted regular charitable coffee mornings.

The service worked hard to retain and develop their staff group. Most staff had been with them since the start of the service, and those who had left had moved into professional training. The registered manager

said, "The staff are amazing we wouldn't have a company without them." The managers liked to support staff development. They saw their staff as the backbone of the service and encouraged staff to become trained and educated in care qualifications. They had a steady flow of job applications. They also liked to support staff well-being by promoting carer of the month and sending birthday and sympathy cards to carers with a close relationship to people. There was a holiday caravan for staff and their families to use. The service had signed up to the BFRS (The British Forces Resettlement Service). The co-director went to their seminars to recruit staff and made links with welfare officers. Staff felt confident to approach the management team and spoke positively of the support they received. One staff member said, "They [management] are always available and very supportive."

People and their relatives spoke highly about the management team and the leadership of the service. Comments included, "It is extremely well managed and the staff have a good rapport with [the managers], "Good communication" and "I would recommend them to anyone." The registered manager and co-director made full use of social media, electronic filing and messaging to aid fast and effective communication. Each staff member had a mobile with safe, encrypted messaging applications, enabling them to access information when needed. Any changes or developments could be communicated to people and staff quickly.