Tetra Care Limited

Tetra Live - in Care

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service caring?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

This inspection took place on 28 June 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. This was the first inspection since the provider registered with the Care Quality Commission in 2011. The provider had only started to provide a regulated activity from September 2015.

Tetra Live-in Care is registered as a domiciliary care provider supporting people living with high level spinal cord injuries with live-in carers providing 24 hour care in their own homes. At the time of the inspection, one person was receiving a live in care service from the provider. This meant that although we were able to carry out an inspection we did not have enough information about the experiences of a sufficient number of people using the service over a consistent period of time to give a rating to each of the five questions and an overall rating for the service.

The service had 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.

Risks to people were documented and managed so that people were kept safe. These were assessed during an initial assessment and thereafter reviewed every six months.

Care records were based around people's preferences and were written in a person centred manner. They were developed by speaking with people and their relatives, and covered a number of areas highlighting where people required support.

Care records included details of people's support needs in relation to their diet and ongoing health monitoring. These were managed appropriately by care workers. Care workers completed records relating to people's diets, health care appointments and medicines in a timely manner.

Care workers received a thorough induction which covered mandatory training and also specialist training based around supporting people with spinal cord injuries. They were familiar with people's preferences and how they liked to spend their day.

Care workers told us they felt support by the management team who were always available to provide advice when needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

Staff had received training in safeguarding adults and were able to identify potential signs of abuse.

Risks to people using the service were managed appropriately.

Thorough recruitment checks were in place.

People received their medicines safely and care workers completed records to show they had done so.

Is the service effective?

Inspected but not rated

Staff completed training relevant to the needs of people using the service.

Peoples had their needs met in relation to their dietary needs.

People were supported to attend healthcare appointments.

Is the service caring?

Inspected but not rated

People were involved in planning their care.

Care records were written in a person centred manner.

Is the service responsive?

Inspected but not rated

People's care and support needs were assessed and reviewed regularly.

Policies were in place to manage complaints.

Is the service well-led?

Inspected but not rated

Staff told us they felt supported.

Care records were well maintained and reviewed regularly.

Tetra Live - in Care

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 28 June 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection was carried out by a single inspector.

Before the inspection took place, we looked at the information the Care Quality Commission (CQC) held about the service.

During the inspection we spoke with the director and two care workers. We were not able to speak with the one person using the service as they were not able to speak with us. The records we looked at included one care plan, two staff records and records relating to the management of the service.

Inspected but not rated

Is the service safe?

Our findings

Care workers had an awareness and understanding of potential abuse which helped to make sure that they were able to recognise potential signs of abuse. All care workers received safeguarding training as part of their annual mandatory training and were aware of the correct reporting procedures.

There were procedures and documents in place for managing risk and care workers understood the risks to people they supported. They were provided with information about risks and supported people to undertake activities in a safe manner. Risks to people were identified during their initial assessment. Steps that care workers needed to take to manage the risks and keep people safe were documented.

People's care needs, including any underlying risks were discussed with them and documented during their initial assessment. These included any risks associated with the use of their wheelchair, any specialist equipment such as hoists, profiling beds and their personal care needs.

An assessment that looked at environmental risk was also completed. This looked at whether the environment that people lived in was safe and if not then what steps could be taken to make it safer. For example, whether there was sufficient space for them, furniture, equipment, fire alarms, electric, gas, emergency contact list, hoisting, moving and handling.

There were robust recruitment procedures in place for potential new care workers. Appropriate checks were completed before care workers began work. This helped ensure that they were safe to work with people using the service.

Staff recruitment took place either through a specialist recruitment website or via the provider's website. Prospective employees had to give details about their previous employment, relevant experience, references, qualifications and a CV. The director told us he met potential care workers to talk through their experience. As he is a person who has been affected by spinal cord injury and employed his own private live in carers he was aware of the issues that needed to be explored when interviewing people.

Staff files contained references, proof of identity and appropriate criminal record checks called Disclosure Barring Service (DBS) checks. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions.

There was a medicines policy in place, advising staff on how to support people with their medicines. Care plans contained a list of current medicines that people were taking and included the level of support that people needed to take their medicines safely. Medicine administration records (MAR) charts were in place and care workers completed these and sent these to the office for record keeping. We saw that MAR charts were ticked rather than signed by the relevant care worker, the director was aware that an accurate record of which care worker had supported people with their medicines was needed. He told us because only live in care workers were employed, they knew which care worker was responsible but agreed to amend this in future with signatures.

Inspected but not rated

Is the service effective?

Our findings

Staff received a thorough induction that gave them the skills and confidence to carry out their role and responsibilities effectively.

The director said that all staff were required to complete an induction and specialised training in caring for people with spinal cord injuries before they started to support people. The mandatory training was refreshed annually and covered equality and diversity, health and safety, fire safety awareness, infection control, food hygiene, manual handling, basic life support, safeguarding adults, complaints, lone working and information governance.

Specialist training in caring for people with spinal cord injuries was provided by an advanced nurse practitioner. They provided training on bowel management, bladder management and autonomic dysreflexia. Autonomic dysreflexia is a syndrome in which there is a sudden onset of excessively high blood pressure. It is more common in people with spinal cord injuries. This was supplemented by active questioning and assessing care workers response to scenarios. The provider had purchased an advanced training mannequin so that people could learn in a practical manner.

All care workers also received a manual on spinal injury that had been developed by the director which covered the following areas, anatomy and physiology of the vertebral column and spinal cord, bowel management, autonomic dysreflexia, urinary management and risks associated with immobility.

Training certificates were seen for mandatory and spinal cord injury training. The director said that formal supervision was not done because of the current size of the service and he was in constant contact with the care workers who were supporting the person using the service.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in domiciliary care agencies are to be made to the Court of Protection.

People received support in their own homes and were not subject to any restrictions on their movement. Care plans were recorded electronically and a copy was kept in people's homes. Although the computer records we saw were not signed by people, people's choices and preferences were clearly documented in the records that we saw.

Care records showed that care workers were required to support people in preparing meals of their choice. Meals were provided by people's families and minimal staff support was required in this area. Care workers had received training in food hygiene.

Care plans included details of healthcare professionals involved in supporting people such as their GP, district nurses, and their pharmacy details. People's medical condition including their level of spasticity, skin conditions and dysreflexia were available for care workers to refer to and details about people's spinal cord injury, how it was being treated and any ongoing check-ups and physiotherapy required were also recorded.

Care workers recorded details of any contact with health care professionals in appointment sheets and diaries were in place to monitor bowel movements.

Inspected but not rated

Is the service caring?

Our findings

People received care and support from staff who knew them and understood their history, likes, preferences and support needs.

The provider offered a live in service and provided care workers who stayed in people's homes as live in care workers providing support throughout the day and night. People were supported by a team of care workers who shared their workload, one care worker was the main live in care worker supporting the person for 3 weeks in a month and a secondary worker covered the final week in a month. This arrangement meant that care workers and people were matched closely according to their needs and preferences and this allowed for caring relationships to develop.

People were able to specify the gender of the care worker they preferred but also the types of activities they enjoyed doing and the type of person they wanted to be supported by. Each care worker completed a profile of themselves which was shown to the person to assess whether they would be suitable. People were provided with assignment sheets with details of who would be supporting them.

People and their relatives were involved in planning their care and were supported to express their views and preferences which were documented in their care records. Care records were written in a person centred manner.

Care workers were aware of the importance of privacy and dignity when supporting people with personal care.

Inspected but not rated

Is the service responsive?

Our findings

People's care, treatment and support was set out in care records that described what staff needed to do to make sure personalised care was provided.

The registered manager carried out initial assessments and the ongoing reviews of people's care needs. The initial assessment was carried out in people's homes and was comprehensive in its scope.

The assessment included an overview of people's living arrangements, the activities they enjoyed, their previous employment, their social situation, current and future housing arrangements, and any adaptation or equipment that was in use such as wheelchair, hoists, profiling bed, their level of social engagement and their preferences in relation to their care worker.

The registered manager looked at a number of areas related to people's care needs including the use of their wheelchair, cushion/mattress, moving and handling, bladder management, bowel movement, dressing/undressing, personal hygiene, skincare, medicines and nutritional intake. Each identified area also included what level of support care workers were expected to provide.

Support plans were in place for people. These were reviewed every six months and included the support that people needed in relation to their morning, daily and evening routine and night time routine. These provided clear steps for care workers to take to help people.

Care plans were reviewed after six months and changes to people's support needs documented. Records of contact between the provider and people or their relatives were available which included notes of conversations discussed over the phone or email.

People were supported to engage in a number of activities that reflected their interests such as attending college or taking part in outdoor activities. We found that support plan monitoring was not always in place to clearly evidence the support that people received. We discussed this with the director during the inspection. Staff told us about the activities that people enjoyed and how they supported them to try and maintain these.

People were given details of how to raise a complaint if they were not happy in their contract which they kept at home. All care workers were issued with a staff handbook which included details of what to do if they were they received a complaint from people they supported.

We saw evidence of communication between the provider and people when concerns had been raised. These were dealt with satisfactorily by the provider. No formal complaints had been received at the time of our inspection but there was a complaints policy in place giving guidance on how to address any complaints that were received.

Inspected but not rated

Is the service well-led?

Our findings

Tetra Live-in Care was founded by the director with the mission to provide excellent support for people living with high level spinal cord injuries. The director had been living with a high level spinal cord injury since 2000 and understood the specific care needs of people with similar injuries and the type of support they needed.

He was supported by a registered manager. Care workers told us they felt well supported and had an "open and honest relationship" with the managers. They said they spoke to them all the time and if they had any issues these were managed well.

The director was heavily involved in the management of the service and was familiar with people's needs. This was evidenced in documents that we saw showing us that people often contacted him directly if they had any issues.

Regular reviews of care plans and risk assessments took place and records such as medicine record charts and other monitoring records were scanned and stored for reference. Records were also available to gather feedback from people using the service but these had not been used as yet due to the short time the provider had been supporting people.

Incidents forms were also in place for monitoring purposes although there had been no notifiable incidents. Staff were aware of the reporting process for any accidents or incidents that occurred and their responsibility to inform management of any occurrences.