Holistic Caring Services Limited

Holistic Caring Services

Inspection report

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Date of inspection visit:
27 February 2018

Date of publication:
04 April 2018

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an announced inspection on 27 February 2018. At the time of the inspection three people were receiving care.

Centrepoint The Top Suite (trading as Holistic Caring Services) is registered with the Care Quality Commission for the regulated activity of Treatment of Disease, Disorder and Injury. This registration is appropriate to the provision of nursing services. However, the service was providing the regulated activity of personal care. We discussed this with the service manager who was also nominated individual. They agreed to submit an application to add personal care to the registered activities as a priority.

A registered manager was in post. However, the registered manager was not available on the day of the inspection. 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 were not recruited safely in accordance with the provider's policy or best-practice. Two of the three files we checked did not contain any evidence that references had been received prior to the person starting work.

A registered manager was in post. However, they were not actively involved in the day to day management of the service. This role was undertaken by the service manager who was also the director and Nominated Individual. This meant that the governance framework for the service was not clear or robust.

The service manager had completed a series of quality and safety audits on a regular basis. However, audit processes were not robust and had failed to identify the lack of references in the staff files that we saw. We made a recommendation regarding this.

The people that we spoke with had no concerns about the safety of services. People were protected from potential harm and self-neglect because staff knew people well and were able to recognise signs of abuse or neglect.

The care files that we saw showed clear evidence that risk had been assessed and reviewed regularly. Risk assessments were sufficiently detailed. Risk was reviewed by staff with the involvement of the person or their relative.

Staff were trained in the administration of medicines but because the services were community-based, they were not always responsible for storage and administration. Some people who used the service were able to self-administer their medicines; others received support from a relative. At the time of the inspection staff were not supporting people with the medicines.

The service manager was clearly aware of the day to day culture and issues within the service. We saw that they knew the people using the service and their staff well.

The service manager was able to articulate a clear vision for the service which maintained its focus on the provision of specialist services for people requiring end of life care. However this focus was not fully reflected in promotional materials or the provider's statement of purpose.

The service manager worked closely with staff as they delivered care. This supported a culture of open communication.

The staff that we spoke with were motivated to provide high quality care and understood what was expected of them. They spoke with enthusiasm about the people that they supported and their job roles.

Care was delivered in accordance with people's needs and choices and in conjunction with healthcare professionals. Policies, procedures and other documents made appropriate reference to legislation and standards including the Care Quality Commission's fundamental standards.

Staff were trained to a basic level in a range of subjects which were relevant to the needs of the people using the service. Subjects included; safeguarding adults, moving and handling, administration of medication, Mental Capacity Act 2005 and equality and diversity. However, there was no evidence that their competency had been formally assessed. We made a recommendation regarding this.

Staff told us they felt well-supported by the service manager and had access to regular supervision. However, the service manager acknowledged that records of supervisions were not always kept. They confirmed that they would address this matter as a priority.

People's capacity was assessed in conjunction with families and professionals and in accordance with the principles of the Mental Capacity Act 2005. None of the people currently using the service were subject to restrictions on their liberty. However, staff were aware of the need to seek authorisation from the Court of Protection if people's liberty needed to be restricted to keep them safe.

People's day-to-day health needs were met by the services in collaboration with families and healthcare professionals.

We did not have the opportunity to observe staff providing care as part of the inspection process. However, people told us that they were very happy with the care and support provided.

The service manager was knowledgeable about each of the people that used the service and each member of staff. People had regular contact with the service manager and were able to contact them using an on-call number if necessary. This meant that the service manager was able to monitor the quality of care through a variety of means.

Where people had difficulty communicating their needs and preferences, staff had additional guidance to support them. For example, one care record explained how the person didn't use speech, but could understand what was being said to them. The person was able to make their views known through facial expressions and body language.

Because of the nature of people's care needs, there were limited opportunities to promote people's independence. However, in one care record we saw instructions for staff to support the person with their

independent choice of clothes and to interact with the person during the process.

We asked people about the need to respect privacy and dignity. People told us that staff respected their right to privacy and were mindful of this when providing personal care.

We saw from care records that people and their relatives contributed to the assessment and planning process and were given choice over each aspect of their care. Care plans had been regularly reviewed and signed by the person or their representative.

Because of the nature of the care provided there were limited opportunities to engage people in activities. However, care records contained information on people's likes and dislikes that staff used in conversation as they provided care.

People were given a number of options if they chose to complain about the service. They could speak directly to staff or the service manager. They could also use the formal complaints procedure. A copy of the procedure was provided to each person when they started using the service.

The service was primarily focussed on meeting the needs of people at the end of their lives. They worked closely with the district nurses and a local hospice to ensure that people had the option to return home with an appropriate package of care in place. The service worked effectively as part of a wider team to ensure that people's personal care needs were met in accordance with their wishes.

You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff were not recruited following a robust process. References had not been received for some staff prior to them commencing work.

The care records that we saw showed evidence that risk had been assessed and reviewed regularly.

People told us that they believed care was delivered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received formal supervision or had their competency assessed.

Staff were required to complete a programme of basic training which covered a range of relevant topics.

People's day to day health needs were met by the services in collaboration with families and healthcare professionals.

Is the service caring?

Good

The service was caring.

People spoke positively about the quality of care provided by staff.

Staff knew people well and told us that they enjoyed providing support to people.

People were afforded appropriate levels of privacy and supported to maintain their dignity at all times.

Is the service responsive?

Good

The service was responsive.

The service worked with people, their relatives and healthcare professionals to produce care plans to a high standard. These plans were regularly reviewed.

People were well supported with end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager was not actively involved with the service on a day to day basis.

Audit processes were not robust and had not identified issues of concern.

The service manager offered leadership and remained approachable to people using the service, relatives and staff.

Holistic Caring 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 27 February 2018 and was announced. The inspection was announced because this is a small service and we wanted to make sure that we visited at an appropriate time for people receiving care. This was the first inspection since the service was registered.

The inspection was conducted by an adult social care inspector.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the local authority who provided information. We used all of this information to plan how the inspection should be conducted.

A Provider Information Return (PIR) was not available for this service. A PIR 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 took this into account when we inspected the service, and made the judgements in this report.

We spoke with one person who used the service, one relative, two care staff, the service manager and an administrator. We also spent time looking at records, including three care records, three staff files, staff training records, and other records relating to the management of the service. We contacted health and social care professionals who have involvement with the service to ask for their views.

Requires Improvement

Is the service safe?

Our findings

Staff were not recruited safely in accordance with the provider's policy or best-practice. We checked the contents of three staff files. Each contained photographic identification, an application form with employment history and evidence of a Disclosure and Barring Service (DBS) check. A DBS check is used to check if applicants have a criminal record and are suited to working with vulnerable people. However two of the three files did not contain any evidence that references had been received prior to the person starting work. We spoke with the service manager and an administrator regarding this and were told that references had been applied for, but not returned. This meant that the provider could not be certain that staff had been safely recruited and were suited to the role. Immediate action was taken to follow-up the reference requests.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people that we spoke with had no concerns about the safety of services. We asked people who used the services and their relatives if they felt safe. Comments included; "100% safe. They come here four times a day. I just couldn't cope without their help. What is more important is that it's the same staff. I don't see lots of different faces" and "Yes. If I'm bad in the morning they're there for me. [Carers] will even phone me if they're stuck in traffic." At the time of the inspection only three people were receiving care. We found there were sufficient staff to provide consistency.

People were protected from potential harm and self-neglect because staff knew people well and were able to recognise signs of abuse or neglect. Staff had completed training regarding adult safeguarding procedures. The staff that we spoke with confirmed that they had attended the training. They were able to explain the different types of abuse and what action they would take if they were concerned that abuse or neglect were taking place. The provider had a range of systems and procedures in place which allowed people using the services, their relatives and staff to raise any concerns. There had been no safeguarding referrals made in the previous 12 months.

The care files we saw showed clear evidence that risk had been assessed and reviewed regularly. Risk assessments were sufficiently detailed. Risk was reviewed by staff with the involvement of the person or their relative. We saw evidence of risk assessments in relation to; the environment, falls and skin integrity. In one example, the level of risk had been reduced because of a significant improvement in the condition of a pressure ulcer.

The provider's approach to whistleblowing was detailed in the relevant policy. The policy contained details of organisations that could process whistleblowing concerns and advise staff. Staff were able to explain internal mechanisms for reporting concerns and were aware of the external resources available to them if required. Each of the staff that we spoke with expressed confidence in internal reporting mechanisms.

Staff were provided with basic training and personal protective equipment (PPE) to help protect people from the risk of infection. Staff understood the importance of using PPE when providing personal care.

Staff were trained in the administration of medicines but because the services were community-based, they were not always responsible for storage and administration. Some people who used the service were able to self-administer their medicines; others received support from a relative. At the time of the inspection staff were not supporting people with the medicines. This meant that we were unable to inspect practice in this area. However, we spoke with the service manager who confirmed that, when required, medicines would be administered in accordance with best-practice and the relevant policy. The medicines policy provided clear guidance regarding; storage administration, record-keeping, covert medicines, topical medicines and PRN (as required) medicines.

There had been no recorded incidents or accidents since the service became registered. We spoke with the service manager about this. They explained the process that would be followed in the event of an incident or accident which included an assessment to establish if lessons could be learnt.

Requires Improvement

Is the service effective?

Our findings

Staff had been trained to ensure they had the right skills and experience to meet people's needs. One person said, "The staff have got all the right skills." A relative commented, "I've had hundreds of carers, but they are the very, very best. They look after [relative] very well." Staff were positive about the quality of the training. Their comments included, "I've had mandatory training. It equipped me well" and "I do on-going training with my manager."

Care was delivered in accordance with people's needs and choices and in conjunction with healthcare professionals. Policies, procedures and other documents made appropriate reference to legislation and standards including the Care Quality Commission's fundamental standards. The fundamental standards are the regulations that CQC uses to measure whether services are being provided in accordance with legislation.

Staff were trained to a basic level in a range of subjects which were relevant to the needs of the people using the service. Subjects included; safeguarding adults, moving and handling, administration of medication, Mental Capacity Act 2005 and equality and diversity. We looked at records relating to training and saw that all training had been completed in accordance with the provider's schedule. We were told that new staff were inducted in accordance with the principles of the Care Certificate. The Care Certificate requires staff to complete a programme of learning and have their competency assessed before working independently. The service manager worked along-side new staff and assessed their competency. However, there was no written evidence to demonstrate that the process had been completed. We spoke with the service manager about the need to maintain accurate records of people's training and development. We received assurance that workbooks would be completed for each member of staff.

We recommend the provider reviews the provision of staff training and the assessment of competency to ensure that it adheres to best-practice guidance.

Staff told us they felt well-supported by the service manager and had access to regular supervision. However, the service manager acknowledged that records of supervisions were not always kept. They confirmed that they would address this matter as a priority.

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. People's capacity was assessed in conjunction with families and professionals. None of the people currently using the service were subject to restrictions on their liberty. However, staff were aware of the need to seek authorisation from the Court of Protection if people's liberty needed to be restricted to keep them safe. We were unable to observe staff, but they told us that they always asked for consent before providing care. The relatives that we spoke with confirmed this.

Staff helped people to prepare and eat nutritious meals as required by their plan of care. The people receiving care at the time of the inspection were able to prepare their meals independently or had a relative to do this for them. However, there were occasions when staff were required to assist. One person had a plan of care developed by a speech and language specialist. This involved the pureeing of food and the use of thickeners in drinks. The staff that we spoke with were clear about their responsibilities in relation to this aspect of care and had access to instructions in the person's home.

People's day-to-day health needs were met by the services in collaboration with families and healthcare professionals. Staff supported people with their healthcare needs and used information to update care plans. We saw evidence in care records that staff supported people to engage with community and specialist healthcare organisations to support their wellbeing. For example, district nurses. We spoke with two healthcare professionals who worked with people receiving care from the service. One person said, "They're absolutely amazing. They've been helpful. They work well as part of our team."

Good

Is the service caring?

Our findings

We did not have the opportunity to observe staff providing care as part of the inspection process. However, people told us that they very were happy with the care and support provided. One person using the service told us, "They all treat me with kindness." A relative said, "They respect you and your home and look after [relative] very well. I don't think [relative] has ever had such good care." The healthcare professionals that we spoke with were equally positive. One of them said, "When we go all the families are complimentary." While the other told us, "Generally, we've had positive feedback."

People were supported by the same staff on a regular basis and the service manager provided additional care and support. When new staff were being introduced they were required to work alongside the service manager on 'shadow-shifts'. This gave people the opportunity to assess whether they wanted the new staff member to be part of their support team. The service manager was knowledgeable about each of the people that used the service and each member of staff. People had regular contact with the service manager and were able to contact them using an on-call number if necessary. This meant that the service manager was able to monitor the quality of care through a variety of means.

Staff told us that they enjoyed providing support to people and were able to explain how they involved people in making decisions about their day-to-day care and support. It was clear from discussions that staff knew the people they supported well. When we spoke with them they described the person and their needs in detailed, positive terms. Where people had difficulty communicating their needs and preferences, staff had additional guidance to support them. For example, one care record explained how the person didn't use speech, but could understand what was being said to them. The person was able to make their views known through facial expressions and body language.

Each care record contained a section which addressed choice and control. People or their relatives had signed the documents to say that they agreed with the contents. People were clear that they had choices regarding how and when support was given. For example, one care record outlined how the person required the use of a device to support their neck. It said, 'Always check with [person] if they want it before applying it.'

None of the people using the service at the time of the inspection was accessing independent advocacy although the people that we spoke with were aware that it was available to them. Information regarding access to advocacy services was included in the service user pack supplied to each person.

Because of the nature of people's care needs, there were limited opportunities to promote people's independence. However, in one care record we saw instructions for staff to support the person with their independent choice of clothes and to interact with the person during the process.

We asked people about the need to respect privacy and dignity. People told us that staff respected their right to privacy and were mindful of this when providing personal care. The service manager told us, "It starts with personal care. We don't over-expose anyone. We close curtains and we don't make people feel

uncomfortable."

Good

Is the service responsive?

Our findings

We saw from care records that people and their relatives contributed to the assessment and planning process and were given choice over each aspect of their care. Care plans had been regularly reviewed and signed by the person or their representative. Each of the people that we spoke with confirmed that they were fully involved in discussions and the review of their care and support needs. One person using the service told us, "I was involved in the review with the agency and the district nurses."

The care records that we saw were sufficiently detailed to instruct staff and contained person-centred information. In one record there was a good level of detail about; family history, life history, medical history, likes and dislikes. This helped staff to get to know the person and provide individualised care which was responsive to the person's needs.

A relative told us how the care provided had helped them to maintain their relationship with their spouse by allowing them to return home after a stay in hospital. They also made reference to the positive impact that the care had on their relative. They commented, "[Relative] was in a state when [relative] first came home. [Relative] has improved and I think the quality of care has helped."

Because of the nature of the care provided there were limited opportunities to engage people in activities. However, care records contained information on people's likes and dislikes that staff used in conversation as they provided care.

People were given a number of options if they chose to complain about the service. They could speak directly to staff or the service manager. They could also use the formal complaints procedure. A copy of the procedure was provided to each person when they started using the service. The complaints procedure was clear and detailed and provided information on how to complain to an external body such as the local authority or the Care Quality Commission. We spoke with the service manager who confirmed that they had not received any formal complaints since they began providing care. The people that we spoke with were clear about what to do if they needed to complain, but each of them said that they had not had to make a formal complaint.

The service was primarily focussed on meeting the needs of people at the end of their lives. They worked closely with the district nurses and a local hospice to ensure that people had the option to return home with an appropriate package of care in place. The service worked effectively as part of a wider team to ensure that people's personal care needs were met in accordance with their wishes. A healthcare professional said, "They tell you everything. They work well as part of our team." Another healthcare professional commented, "We deal with discharges and outside referrals. Once we make a call they respond quite quickly."

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post. However, they were not actively involved in the day to day management of the service. This role was undertaken by the service manager who was also the director and Nominated Individual. We asked the service manager about this arrangement. They confirmed that the business was not currently large enough to sustain the registered manager in a full-time position. The exact nature of the role of the registered manager was unclear. This meant that the governance framework for the service was not clear or robust.

Centrepoint The Top Suite (trading as Holistic Caring Services) is registered with the Care Quality Commission for the regulated activity of the Treatment of Disease, Disorder and Injury. This registration is appropriate to the provision of nursing services. However, the service was providing the regulated activity of personal care. We discussed this with the service manager who was also nominated individual. They agreed to submit an application to add personal care to the registered activities as a priority.

The service manager had completed a series of quality and safety audits on a regular basis. Audits were completed monthly and focused on; medicines, the physical environment, risk and care plans. However, audit processes were not robust and had failed to identify the lack of references in the staff files that we saw.

We recommend the provider reviews its approach to safety and quality auditing to ensure that processes are robust.

The service manager was clearly aware of the day to day culture and issues within the service. We saw that they knew the people using the service and their staff well. They explained that there had been no notifiable incidents since the service began.

The service manager was able to articulate a clear vision for the service which maintained its focus on the provision of specialist services for people requiring end of life care. However this focus was not fully reflected in promotional materials or the provider's statement of purpose. These documents described a wider range of care services for older people. We discussed this with the service manager who confirmed that some documents would be reviewed to ensure they remained accurate.

The service manager worked closely with staff as they delivered care. This supported a culture of open communication. One of the staff told us, "Communication is very good." While a different member of staff said, "Communication is generally good. [Service manager] is a very good leader. [Service manager] leads by example."

The staff that we spoke with were motivated to provide high quality care and understood what was expected of them. They spoke with enthusiasm about the people that they supported and their job roles. Each of the staff was positive about the support and quality of care offered by the organisation. Clear guidance for staff was available through a comprehensive set of policies and procedures which had been purchased from an external specialist. Documents had been regularly reviewed and included important

information about; administration of medicines, safeguarding, complaints and whistleblowing.

Because the service was so small and people received care on a short-term basis, the provider had not developed any formal mechanisms for engaging with people who used the service. We spoke with the service manager regarding this and we were told that formally obtaining people's views was difficult because people were receiving end-of-life care.

The service manager was knowledgeable about their role and the organisation. They were able to provide evidence to support the inspection process in a timely manner and facilitated meetings with service users, family members and staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff had not been safely recruited in accordance with regulation. Staff references had not always been secured before they started work.