Care Quality Commission

Yourlife Management Services Limited

Your Life (Cheltenham)

Inspection report

Jenner Court
St Georges Road
Cheltenham
GL50 3ER

Tel: 01242571704
Website: www.yourlife.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 March 2016 and was announced.

Jenner Court is a complex of 68 privately owned one and two bedroom apartments. There is a communal lounge, a restaurant and gardens which were used by the people who lived there. Staff from the provider's domiciliary agency provided a range of supportive services. This inspection focused on the part of that service which provided support to people with their personal care needs. At the time of this inspection 10 people were receiving this type of support.

The general manager of the complex was registered with the Care Quality Commission in respect of this activity. A registered manager is a person who has registered with the Care Quality Commission to manage such a 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. This manager had however notified us that she was due to leave on 20 April 2016.

People told us they always felt safe and secure. People's rights were upheld and there were processes in place to protect them from harm and abuse. They told us they enjoyed being supported by the same group of staff who they knew and liked and who knew what their needs were. This continuity was possible because staff who worked for the provider's domiciliary care service were purely based at Jenner Court. Staff had received training and support to be able to meet these needs. People told us staff received care when they expected to and for the full designated time. They told us that if the staff were running late they were informed about this. They also confirmed this was rare. Staff told us the time they were given to provide people's support in was sufficient for them to do this in an unrushed manner.

As more people had wanted this type of support additional staff had been recruited in December 2015. Recruitment processes had been robust and therefore people were protected from potentially unsuitable staff. There had been some periods of time where there had been one member of staff on duty able to provide care. Apart from some reported incidents when care had to be interrupted in order for the staff member on duty to take an incoming call this had not had a negative impact on people. The registered manager however told us it was not ideal and would aim to avoid this level of staffing. People mostly arranged their own health care appointments, such as visits to and by their GP, dentist and optician. Many had family members who also supported them in doing this but if this were not the case staff would be available to help. Where staff provided people with help to manage their medicines.

People had care plans which outlined what their needs were and how these should be met. Care plans had been formulated and reviewed with the individuals receiving the support; sometimes people's family represented them. People had full access to these records as copies were kept in their homes. Care plans needed some improvement to make them more specific and relevant to the person's needs. As people were able to direct staff and staff communicated well between each other, this lack of written guidance had not had a negative impact on anyone. The potential risk to people resulting from a lack of accurate information about their needs had been recognised and work had started to improve the accuracy of people's care plans. The registered manager told us they had wanted to up-skill some staff to be responsible for doing this as they considered them better placed to do this. They told us this was not going to be achieved before they left but they hoped it would remain something that the next manager could support.

There was a process in place for people to be able to raise a complaint, have this listened to, investigated and resolved although none had been recorded since the last inspection in May 2014. Various meetings and an open door policy enabled people to raise ideas, suggestions and areas of dissatisfaction with the registered manager. There were mixed views on how effective the management were in responding to their feedback.

The provider had already organised for an interim manager to manage the service until another permanent manager was appointed. The provider had quality monitoring processes in place to ensure the service remained compliant with various areas of regulation and legislation. Changes in the area management support to the service had also taken place recently. A fresh review of the service's management, processes and systems was therefore due to take place soon in order to support future improvement of the service.

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 as safe as it could be. There had not always been enough staff available to ensure people received their care in the way it had been planned to be delivered.
Arrangements in place did not fully protect people from potential errors relating to the administration of their medicines, in particular the application of some ointments and creams.

People's risk, including those relating to falls and the environment were identified and managed.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

People were protected from those who may be unsuitable to care for them because good recruitment practices were applied.

Is the service effective?

Good

The service was effective. People received care and treatment from staff who had been trained to provide this.

People consented to the care provided. Staff were aware of the principles of Mental Capacity Act (2005) which protected people when they lacked mental capacity.

Where needed people received appropriate support to access food and drink which helped maintain their well-being.

People had access to health care professionals and if needed staff would support them to achieve this.

Is the service caring?

Good

The service was caring. People were cared for by staff who were kind and who delivered care in a compassionate way.

People received care and support which was tailored to their individual needs and preferences.

People's dignity and privacy was maintained.

Is the service responsive?

Requires Improvement

The service was not as responsive as it could be. Care plans sometimes lacked detail and enough guidance for staff.

There were arrangements in place for people to raise their complaints and to have these listened to. People did not consider the management overly good at always addressing areas of dissatisfaction.

Is the service well-led?

Good

The service was well-led. People had opportunities to meet with the registered manager, communicate with her and put forward their ideas and suggestions.
A permanent management presence in Jenner Court over the last six months had provided some continuity for people and staff.

The provider had in place quality monitoring processes which had enabled them to maintain compliance and monitor the levels of service.

Your Life (Cheltenham)

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 10 and 11 March 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure the registered manager would be in.

Prior to our visit to the service we reviewed the information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

One inspector carried out a visit to the provider's domiciliary care agency (DCA) office at Jenner Court and to the private residences of people who use this service within Jenner Court. At the time of the inspection 10 people received support with their care needs from the DCA. We spoke with six of these people and one relative.

We also spoke with the registered manager and two members of care staff. In addition we reviewed seven people's care records which included risk assessments and care plans. Where people received support with their medicines we reviewed their medicine administration records. We reviewed two staff recruitment files. We also looked at records relating to the management of the service. These included staff duty rosters, the staff training record, staff meeting minutes, the service's audit file and the complaints file. We reviewed the safeguarding policy and emergency / business continuity policy and emergency response folder.

Requires Improvement

Is the service safe?

Our findings

People told us their needs were met in an unrushed way and they were supported by staff for their full expected visit time. They told us staff turned up when they were expecting them and if they were going to be late, (people told us this was rare); they received a telephone call telling them of the delay. One person told us there had been a couple of times in the last few months when their care had been interrupted because the staff member had to answer the service's mobile telephone. On these occasions there had been one member of care staff on duty. The person told us they felt they had needed to say "they could manage" so as to help the member of staff out. The person confirmed this had not had a negative impact on them because it had happened at a point during their visit where they were able to manage independently. They were however worried that this may not always be the case. Other people told us they were aware that sometimes there had only been one member of staff on duty but they had not been put in a similar situation. We fed this back to the registered manager with the person's permission.

The registered manager confirmed there had been times when only one member of staff had been on duty. They explained that a duty manager was always on duty and sometimes they had been the only member of the care team on duty. On these occasions they were responsible for both the care visits and taking incoming telephone calls. Additional care staff had been recruited in December 2015 and the registered manager explained this had helped with the staffing of the service. They told us they were unaware that people's care and support had been interrupted during these times. We reviewed past duty rosters going back to January 2016. There were 10 occasions when a duty manager was the only member of staff on duty. The registered manager told us it had not been possible to organise additional staff cover during these times. The times were predominantly for a few hours at weekends and in the evenings. We asked what would happen if there was an emergency, for example; a person was taken ill or fell. The registered manager explained that when people activated their emergency call bell a call went through to the duty manager's mobile phone and a call centre. If the call centre received no contact from the duty manager they automatically organised the dispatch of emergency services. The registered manager explained that even if the duty phone was not responded to, for example when the member of staff was in the middle of delivering care, the emergency would still be managed.

The registered manager was going to investigate how shifts were managed where there had been only one member of staff on duty. They agreed that ideally there should be two staff on duty.

Where required staff managed people's medicines for them. They had received training to do this and their competencies in this task were checked. Audits of people's medicine administration charts were carried out. The audit checked to ensure people's medicines, ointments and creams had been administered. However, care plans did not always provide enough specific guidance about the application of people's creams and ointments. For example, one person's care plan recorded the application of a cream and ointment to the person's "legs". One of the ointments was prescribed for a specific area of one leg and if used elsewhere could cause irritation. This level of detail was not in the person's care plan, on the medicine administration record or the ointment tube. There had been no negative impact from this lack of guidance because the person involved knew where the ointment should be applied and could explain this to the staff. However, a lack of guidance for new staff could potentially mean the person's cream and ointment could be incorrectly administered. We fed this back to the registered manager who told us they would make the instructions in relevant care plans more specific.

People told us they felt safe and secure. Comments included: "I completely trust the girls (care staff)" and "I feel absolutely safe and secure here." People were protected from the risk of abuse because staff understood how abuse may present itself. They knew how to report concerns around this and how to contact relevant external agencies who also have a responsibility to safeguard people. They were aware of the company's policy and procedures and of the county council's safeguarding protocols. An informal daily check was carried out on everyone in the morning to ensure they were well and secure. People told us they would speak to a relative or would feel quite happy speaking with a member of staff if they had any concerns. The registered manager was not aware of any safeguarding issues since she had been in post.

Appropriate staff recruitment processes also helped to protect people from those who may not be suitable to care for them. The recruitment files showed that appropriate checks had been carried out before the staff member started work. Clearances from the Disclosure and Barring Service (DBS) had been requested. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been sought from previous employers and in particular, when past jobs had been with another care provider. Employment histories were requested and the reasons for any gaps in employment were explored at interview.

People's risks were identified, assessed and measures put in place to minimise these. Potential risks predominantly included those relating to infection control, moving and handling and potential falls. Risk assessments were completed in order to establish levels of risk and risk management strategies implemented to minimise risks to people. For example, in one person's apartment a large rug had been rolled up and stored so as to prevent a trip or fall. Staff told us they were always vigilant and reported potential risks back to senior staff. Where a person had required equipment to help them transfer from for example, chair to wheelchair or bed an assessment by an occupational therapist had been carried out prior to equipment being introduced. Staff had then received specific instruction on how to use this equipment. Personal protective equipment such as gloves and aprons were used to prevent the spread of potential infection when providing personal care.

There were arrangements in place for the management of unforeseen emergencies. A folder was available for staff with contact numbers to be used in various emergency situations.

Good

Is the service effective?

Our findings

When we asked people about staffs' skills and knowledge they said, "They're very good at what they do" and "The staff are very good here". People considered the staff to have the correct skills and knowledge to deliver their care. They told us staff met their needs effectively and competently. One person said, "I could not be happier with the care" and another person told us they felt the standard of care had "got better".

Staff received induction training when they started work with the company and then received on-going update training and support. Staff recruitment files showed staff had completed induction training and had received support sessions with the registered manager. Induction training and mentoring support helped staff to acquire basic skills and knowledge to carry out their work safely. On-going training and support aimed to help staff develop their skills, knowledge and confidence further.

The registered manager also held a nationally recognised qualification which helped her identify training needs. They were aware of the care certificate and showed us evidence that the provider's induction training was linked to this. The care certificate lays down a framework of training and support which new care staff can receive. Its aim is that new care staff will be able to deliver safe and effective care to a recognised standard once completed. The registered manager confirmed that all care staff employed had already completed a national qualification in care such as the National Vocational Qualification (NVQ) and that all duty manager's held this qualification at a supervisory level as well. So the staff employed were all experienced care staff.

The registered manager provided one to one staff supervision sessions where staff performance could be discussed along with any concerns staff may have as well as their training/support needs. One member of staff told us they had received a "good induction" and received "regular supervision". They described the team and registered manager as being "very supportive". Another member of staff said they had not had supervision for a while however they were being supported to achieve further qualifications in care.

We spoke with the registered manager about safe moving and handling training and First Aid training. Prior to the inspection we had received information of concern which stated that falls were not managed correctly or safely. The registered manager explained that a duty manager always attended a person following a fall. All duty managers had completed an approved first aid course and all other staff received basic first aid awareness training. The service did not have a falls policy but the registered manager explained the moving and handling training, which all staff received, was tailored to the support provided at Jenner Court. Unlike a care home, Jenner Court did not have moving and handling equipment designated for use in the event of a person's fall. Such equipment was only present in people's own accommodation if the person required this to deliver their personal care. In the event of a fall at Jenner Court the person was checked for injuries by staff qualified to do this; the duty managers. If they were then able to stand, with minimal assistance, the person was supported to do this. The registered manager told us staff would only use the techniques taught to them in their moving and handling training. The registered manager explained that if for any reason the person could not independently stand or it was felt to be unsafe to attempt this emergency services were called to assist. The registered manager said, "Staff here are good at knowing what their limitations are and they would call for appropriate help". One member of staff confirmed that falls management had been a topic of discussion in a staff group supervision session.

Staff were aware of the Mental Capacity Act 2005 and had received training on this legislation and how it impacted on their work. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At Jenner Court people received care for which they gave consent. One person lived with dementia however, they could provide consent for their care as and when it was offered and provided. This person's family provided representation for their relative and confirmed this to be the case. This person's family had the appropriate power awarded through the Court to be able to do this.

At the time of the inspection no-one was nutritionally at risk. Some people required their meals to be prepared for them. Others needed staff to ensure their drinks were close to hand and replenished during care visits so they were not at risk. One person required a particular drinking receptacle so they could drink safely. People and staff told us the restaurant on site was used frequently by people for their main meals.

People had access to health care professionals when they needed this but this was predominantly organised by the people themselves or a family member. People told us they organised their own visits to their GP, dentist and optician. Some people had organised a visiting chiropodist. One person had a regular visit from a community nurse but organised these visits themselves. Where needed, as in the case of the person who required moving and handling equipment, staff liaised with health care professionals and took their advice. We were told by the registered manager that when people needed support to access health care professionals the family was first approached to do this, however, if support were needed from the staff this would be provided.

Good

Is the service caring?

Our findings

People told us the staff were very caring and compassionate and each person spoke highly of the staff. Comments included: "I feel I'm cared for", "The girls are lovely, they do everything they can to help when they visit", "They are all very nice and (name) is brilliant, she is so thoughtful" and "Absolutely wonderful staff here". One person also spoke of a time when a member of staff had shown real compassion and concern for them at a very difficult time and they had always appreciated this.

People had very positive relationships with the care staff who supported them. Care staff knew the people they looked after well; they knew what their likes and dislikes were and aimed to consider these when they provided people's care. One person told us the information about their past life had been recorded incorrectly and they were going to adjust this. Another person said, "My care is fully personalised to my needs and preferences". A member of staff confirmed that there was time in people's visits to provide "unrushed and personalised care". Another member of staff said, "There is enough time to get the work done". There was evidence that people were making independent choices about their care and daily activities.

People confirmed they made decisions about their care and that staff respected these. One relative was involved in doing this on behalf of their relative and confirmed they were able to talk to staff and managers about any changes in the person's care.

People's care was delivered in the privacy of their own accommodation. One person specifically commented about how staff showed them respect. They said, "I like all the care staff, they certainly treat me with dignity".

The staff recognised and respected the private relationships people had with friends and family.

Requires Improvement

Is the service responsive?

Our findings

People had a care plan which was held in their own home so they had access to this. Copies were also kept electronically as well as back up paper copies in the care office; both were held securely. Information about people's care was kept confidential and only shared with relevant others if people had given permission for this to happen. People knew the content of their care plan because they had been involved in giving information for its creation, asked to read it and agree with the content if it were correct. People told us they agreed with their care plans; some however were in the process of being reviewed. People told us that staff recorded the care they delivered each time they visited and the records showed this to be the case.

We found the care plans sometimes lacked detail and specific guidance for staff. For example, one person told us the staff put their commode by their bed when they went to bed, emptied this for them in the morning and made their bed. None of this was in the person's care plan. Another care plan required altering to make it clear that a specific task had been assessed as safe to be carried out by one member of staff. The registered manager amended the latter during the inspection so staff were clear about this and told us she would also discuss this issue with the staff. The registered manager explained they had been busy converting people's care plans and assessments onto the provider's new format. They explained they were the only member of staff who currently wrote people's care plans. The registered manager told us that some of the gaps in detail stemmed from a need for some care plans to be reviewed and others were where better communication about changes in care needs was needed. The registered manager told us she had wanted to upskill some staff to take a lead in formulating and reviewing care plans. She considered this to be a more appropriate role for some staff as they predominantly took a lead on people's care delivery. She was aware this was not going to be fully implemented before she left but hoped it would be something that the new manager would be able to implement.

The registered manager had taken steps to improve communication in the care team generally by introducing a communication book and wipe-board in the staff room. She said this was being used effectively by staff and had improved communication. For example, staffed passed on information about falls which happened on a member of staff's days off, information about cancelled calls and changes in appointments. This method of communication was in addition to the information which was handed to staff each day by the duty managers. Due to these systems being in place and people being able to tell staff what they needed doing the gaps in the care plans had not had a negative impact. Where one person was not able to do this their relative and the care staff who 'lived in' with the person (from a different care provider) were actively involved in updating this person's care plans. The registered manager was aware the care plans needed to be more specific in content as this could potentially lead to people's needs not being effectively met.

People told us they were able to raise areas of dissatisfaction and complaint. They were aware of how to do this and had received information on the provider's complaints process. There were differing views about how successful the management were in addressing some areas of dissatisfaction. One area of dissatisfaction was not care related but people told us it had remained unresolved. One person said, "It can take a while for things to be sorted out" and another said "You can mention something and no-one comes back to you about it". Another person had found the management and the registered manager to be very helpful when they had needed to express dissatisfaction. We reviewed the service's complaint file and no complaints had been recorded since our last inspection in May 2014. One person said, "I know how to make a complaint if I needed to but I have no complaints".

Good

Is the service well-led?

Our findings

People had mixed views on how the service had been managed. People we spoke with were all happy with the standard of care they received but felt general communication between them and the management needed improvement. There was evidence to show that the registered manager had held regular meetings with people. The registered manager told us she was regularly "out and about" in the building so met people on a regular basis. This was confirmed by some of the people we spoke with. The registered manager told us this gave people an opportunity to talk to her although her office door was also always open. She confirmed people often fed back ideas and views on the service during these times. Some people confirmed they felt what they had to say had been listened to and others did not feel this to be the case. There were mixed views from staff about how well they thought the service was managed.

The registered manager explained their role as general manager of the complex often meant they were focused on all manner of issues that predominantly related to the building, the general services provided and the viewing of private accommodation by people who potentially wanted to purchase an apartment in Jenner Court. They told us that although they did sometimes get involved in delivering care they were very reliant on the duty manager's to take a lead on this.

The registered manager had managed the service for the last six months. She had notified the Care Quality Commission that she was due to leave on 20 April 2016. People and staff had been informed of this. The registered manager told us the provider had already made plans for an interim manager to replace her. This manager would manage the service until a new and permanent manager was appointed. One person said, "I hope this time round that the temporary manager they (the provider) have in mind is on site more regularly than before". They referred to a period of time prior to the registered manager's appointment when they told us this had not been the case. We were told that the proposed manager was known to some people and staff already. People spoke positively about this manager.

In the last few months there had been alterations in the service's area management team. The registered manager's immediate line manager (an area manager) had left in January 2016. The registered manager explained they had still received support and quality monitoring processes had continued. Audits seen during the inspection included an audit of the safeguarding processes. This was last completed in December 2015 and there had been no actions required from this. Staff files were last audited in October 2015, some actions were issued following this but these had not yet been signed off as completed. The last main audit of the medicine system was completed in July 2015. The registered manager explained however that each person's medicine administration record (MARs) was audited each month as well as a check on the medicines system generally and staff competencies. We saw monthly audits of people's MARs in their care records. The last care plan audit was in July 2015 and was signed off as completed in September 2015 when the provider new format came in. The registered manager told us she was not aware of any outstanding actions stemming from the monthly audits completed in her time at the service.

The last quality monitoring visit on behalf of the provider had taken place in February 2016. The registered manager told us these visits were usually monthly but had not been because of the management changes.

They told us there was a quality monitoring visit planned for the near future. We were informed this visit would look to check that there were no uncompleted past actions and a new period of monitoring would begin. Although we did not see related evidence during this inspection, the registered manager told us the provider's quality monitoring process had been altered. This was to ensure it fell in line with the areas of enquiry used by the Care Quality Commission to assess compliance and standards of service. This would better enable the provider to ensure they were focusing on the required areas of compliance. To support this work we were informed of the new appointment of a company compliance manager.

Overall systems had been maintained to ensure people were safe and that they received the care support they needed. The provider had maintained a general oversight of how the service was performing. In moving forward continuity in the immediate management of the service and the provider's line management support was needed to ensure the service could further develop for the benefit of those who used it.