Chloe Drury Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We undertook an announced inspection on 11 April 2016. At our previous inspection on 13 May 2014 the service was meeting the regulations inspected.

Chloe Drury Limited operates under the brand name Caremark (Sutton). Chloe Drury Limited provides personal care and support to people in their own homes. This includes a service to younger and older adults, and those living with physical disabilities, mental ill-health and/or dementia. In addition Chloe Drury Limited provides an escort service for children, and social and domestic calls to older people. At the time of our inspection 72 people were receiving a service, 66 of whom were receiving support with their personal care.

The service had a registered manager. 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. At the time of our inspection the registered manager was on leave. The managing director and operational director were managing the service whilst the registered manager was away.

People received the support they required with their personal care. Assessments were undertaken to identify people's support needs. People were involved in discussions about their care and support. Plans were developed detailing the level of support people required and how people wanted that support delivered. Care workers were clear about what duties they were required to perform at each appointment. They involved people in discussions and offered them choices about their care.

Staff worked with people to identify risks to their safety, health and welfare. Staff discussed with people those risks and worked with them to develop risk management plans. Staff supported people with their health needs. Staff were knowledgeable about signs that a person's health was deteriorating or their risks had increased, and supported people to obtain the advice and support they required. Staff liaised with people's GP or emergency services if they had concerns about a person's health. Staff supported those people that required it with their medicines, and checked that people took their medicines as prescribed.

There were sufficient staff to meet people's needs. Systems were in place to ensure staff attended people's homes in line with their care packages, and to ensure care workers attended visits on time and stayed the required length of time. There was sufficient time built into staff rotas to accommodate travel time between visits.

Care workers were matched to people based on their personalities, skills and backgrounds. People were asked about their cultural and religious needs and the management team allocated staff who were able to meet those needs. The management team were rolling out a programme to develop staff's understanding of different cultures to help break down barriers and aid understanding.

Staff received the training and support they required to undertake their role. A programme was in place to provide refresher training to staff to ensure they had up to date knowledge and skills. The management team also liaised with the local NHS trust and hospice to provide staff with additional training. Care workers received regular support from their supervisor and were in frequent contact with them.

Staff were aware of their legal responsibilities and the provider's internal policies and procedures. This included understanding their responsibilities in regards to safeguarding adults, the Mental Capacity Act 2005 and incident reporting. The management team liaised with the local authority as appropriate if they had concerns regarding safeguarding procedures or people's safety.

The management team reviewed the quality of service delivery. This included undertaking spot checks, completing competency tests and reviewing the quality of care records.

The management team liaised with other organisations to share learning, build links with the local community and to identify how they could further support people with certain health diagnoses. The staff offered additional services in line with people's interests and to help reduce social isolation. This included a therapy pet service and coffee mornings.

The management team were aware of their CQC responsibilities and adhered to the conditions of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were sufficient staff employed to ensure people received the support they required at the time specified in their care package. Staff rotas took into account travel time to ensure staff were able to attend visits on time.

Staff were knowledgeable about safeguarding procedures and incident reporting. Any concerns regarding a person's safety was discussed with the management team. Assessments were undertaken to identify risks to people's safety and staff worked with people to develop a risk management plan.

People who required it received support with their medicines, and people received their medicines as prescribed.

Is the service effective?

Good

The service was effective. Staff received the training they required to undertake their roles. Competency tests were undertaken to review staff's skills before supporting people unsupervised. Staff received the support they required to undertake their role, including regular contact from their supervisor.

Staff adhered to the principles of the Mental Capacity Act 2005 and ensured people consented to the support they received.

Staff supported people with their nutritional and health needs. Staff ensured people had access to food and drinks throughout the day. If staff were concerned about a person's health they informed their relatives and obtained support from a relevant healthcare professional.

Is the service caring?

Good

The service was caring. Care workers and people were matched according to people's preferences, interests and backgrounds. People were asked about their religious and cultural needs and these were included in people's care packages.

Care workers spoke to people in a way they understood. They offered choices to people and involved them in decisions about

their care.

Staff had received additional training and support from a local hospice to provide them with the skills to support people requiring end of life care.

Is the service responsive?

Good

The service was responsive. People's support needs were identified during an assessment process and detailed plans were developed to inform staff about how to meet those needs. Care workers were provided with information about the level of support people required and what they were able to do for themselves.

People, and their relatives, felt able to express their views and raised any concerns they had with the management team. A process was in place to record and respond to complaints received.

Is the service well-led?

Good

The service was well-led. Staff felt supported by their managers. There was open communication amongst the staff team and all staff were encouraged to express their views about the service.

Systems were in place to provide support to care workers out of office hours. Systems were also in place to review the quality of care and ensure staff delivered support in line with people's care packages. This included monitoring staff's arrival times and time spent at people's homes.

The management team liaised with other organisations to build links in the community and to share information about what support people required from home care.

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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 11 April 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 that someone would be in.

Prior to this inspection we reviewed the information we held about the service, including the statutory notifications received. Statutory notifications are notifications that the provider has to send to the CQC by law about key events that occur at the service. We also reviewed the information included in the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we sent questionnaires to staff, people using the service and their relatives to obtain feedback about their experiences of the service. We received 15 questionnaires from staff, 14 from people and four from relatives. We used the feedback to inform our inspection planning and our judgments about the quality of service provision.

During the inspection we spoke with the managing director, operational director, training manager and one of the care co-ordinators. We reviewed seven people's care records and five staff records. We reviewed records relating to the management of the service including incident reports and complaints.

After the inspection we spoke with a representative from the local authority, a field care supervisor, six care workers, two people using the service and five people's relatives.

Good

Is the service safe?

Our findings

One person told us having the care workers around made them feel safe. Staff were aware of their responsibilities to safeguard people from harm. Staff were aware of the signs and symptoms of possible abuse and told us they would discus with the office staff or local authority if they had concerns about a person's safety or welfare. The management team liaised with the local authority's safeguarding team if they had concerns a person was being abused.

There were sufficient numbers of staff employed to support people. The care co-ordinator told us they had not had any recent missed visits, and there were sufficient staff to cover when people's regular care workers were on leave or off sick. Some people required the support of two care workers. The care coordinators organised staff rotas so the same two care workers worked together, to ensure staff arrived at people's homes at the same time and there was consistency in the care provided. Care workers' rotas took into account the time taken to travel between visits so that people received their care at the time and for the length of time specified in their care package. Care workers were allocated to support people who lived close together to reduce travel time and potential delays. It was also taken into account if care workers travelled using public transport and the time it took to travel between visits. The care workers we spoke with told us they were provided with sufficient time to travel between visits and ensure people received support at the time they required it.

Safe recruitment practices were followed to ensure suitable staff were employed. This included ensuring staff had relevant experience and qualifications. Among recruitment checks that were carried out, criminal records checks were completed, references from previous employers were obtained, people's identity and their eligibility to work in the UK was checked to ensure appropriate staff were employed to work in a caring role.

During the assessment process staff identified any risks to people's safety. Any risks identified were discussed with people. People were involved in the development of risk management plans and staff supported people to manage any risks identified. This included risks associated with moving and handling, mobility, medicines and malnutrition. Information was also included about what equipment was used to support people to manage these risks, for example, if they used a hoist to support with transferring or a walking frame to reduce the risk of falls. Staff had been trained in recognising signs that a pressure ulcer was developing and checked people's skin integrity during personal care. Barrier creams were applied to reduce the risk of skin breakdown. If care workers were concerned about a person's skin integrity this was discussed with their field care supervisor. Some people using the service had a pendent alarm and staff ensured they were wearing them or had them nearby.

Staff were aware of their responsibility to report and record any incidents that occurred. Staff were aware of the process to follow and inform a member of the management team about any incidents that occurred. We saw that a member of the management team reviewed all incidents and ensured appropriate action was taken at the time of the incident and ongoing to support the person and reduce the risk of the incident recurring.

Those who required it received support with their medicines. People's support plan identified if people required support with their medicines and the level of support they required. However, whilst we saw those people who required support with their medicines had a medicine administration record (MAR) detailing their medicines, details of the medicines they took were not included in their support plan. This meant there was a risk that staff would not know which medicines were referred to in people's support plan, for example if they had more than one medicine for the same concern. People told us they received their medicines and staff checked that they had taken them. However, we observed that the MARs detailed the number of tablets given but there was no specific recording of each medicine given. Therefore, an accurate record of medicines given was not consistently maintained. We spoke with the operational director about this who said they would adjust the records to clearly record what medicines were given and when.

Good

Is the service effective?

Our findings

People were cared for by staff who had the knowledge, skills and values to undertake their role. As part of the recruitment process the management team assessed staff's attitudes to ensure they were in line with the service's values of providing a caring service that empowered people to be as independent as possible. Skills tests were also undertaken as part of the recruitment process which included assessing staff's understanding of public transport routes to ensure staff allowed sufficient time to travel to different visits. Competency tests and observations were completed to ensure staff had the skills to administer medicines and to undertake safe moving and handling techniques.

Staff received all the training which the provider considered mandatory to their role before supporting people unsupervised. This included training on infection control, food hygiene, nutrition and hydration, continence care, prevention of pressure ulcers, dementia and communication. Staff were also offered refresher training to ensure they updated their knowledge and skills. This included training on moving and handling, and safeguarding adults and children. Topics such as the Mental Capacity Act 2005 were discussed during team meetings to aid staff's understanding of their responsibilities. Some staff had not completed the required refresher training to ensure they updated their skills. The management team had a system in place to identify which staff were due training and were in the process of booking staff onto the required courses. The management team had organised for the local NHS trust and hospice to provide additional specialist training in mental health, epilepsy and end of life care. Staff told us they were supporting more people with dementia and those who behaved in a way that might challenge staff. The training manager told us they were in the process of sourcing training courses to support care workers to improve their knowledge and skills in these areas.

The majority of staff had received regular supervision and annual appraisals. For the few staff who were due supervision and an appraisal, the management team told us they would ensure these were scheduled by the field care supervisors to enable them to comply with internal procedures and ensure staff were supported. The care workers we spoke with told us they saw their supervisor regularly and had regular contact with them. They told us their supervisor frequently came to see them at people's home and was available if they had any questions or needed additional support.

Staff supported people to attend to their health needs. If care workers were concerned about a person's health this was discussed with the senior staff. Staff liaised with people's families as appropriate and made contact with people's GP if the person needed support making a healthcare appointment. We saw from people's daily records staff supported people in line with guidance provided by specialist healthcare professionals involved in their care, for example advice from occupational therapists regarding use of mobility equipment. If staff were seriously concerned about a person's health they told us they called the emergency services and stayed with the person until they arrived.

Staff supported people with their nutritional needs. People's support plans identified whether people required support at mealtimes and the level of support they required. Staff ensured they left people with access to food and drink throughout the day. One person's records instructed staff that they had previously

been admitted to hospital due to dehydration and they needed to be encouraged to drink more throughout the day. We saw on their log sheets that staff had provided the person with drinks at each appointment.

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. We checked whether the service was working within the principles of the MCA.

Staff were aware of their responsibilities in relation to the MCA and adhered to the MCA code of practice. Staff had received training on the MCA and were aware that they were to assume people had capacity to make decisions unless they had any information that suggested otherwise. If staff had concerns that a person did not have the capacity to consent to decisions about their care this was discussed with the local authority. We saw from the information that was included in people's care records that people had been involved in decisions about their care and had consented to the support they received.

Good

Is the service caring?

Our findings

People, and the relatives, we spoke with were happy with the support they received from staff. One person said in regards to their care worker, "they're fantastic." A person's relative told us their family member and their care worker often shared "a laugh and a joke together." Another person said their care workers were "efficient and kind" and they were "so happy with them all and the office staff." A relative said the care workers were "lovely people…I couldn't praise them enough."

Staff were matched with people to ensure people received the support they required from staff who had the skills to meet their needs. Staff were also allocated according to their background, interests and personalities to ensure people received support from care workers they got on with. Staff had developed a caring relationship with people and had further got to know what interests and hobbies they had, which helped engage people in conversations and activities during visits to reduce the risk of social isolation. Care workers told us they were introduced to people by the field care supervisors or a member of the management team before providing them with support, so that people did not have strangers entering their homes.

During the assessment process staff liaised with people to identify their preferences, particularly in regards to the gender of the care worker who supported them and information regarding religious and cultural practices. This information was taken into account during the process of identifying which staff were suitable to support each person. Staff worked with people to identify why they did or did not want support from a staff member with a particular characteristic to help break down barriers. The operations manager had recently completed a course on 'cultural intelligence' which looked at internal bias and stereotyping. The management team had started to use a 'cultural intelligence' test with all staff to identify any bias staff had and worked with them to reduce those assumptions and judgements. In this way the provider demonstrated that they actively promoted all people's rights and showed respect for their diversity.

Care workers told us they were respectful of people's individuality, and worked with people to ensure they were comfortable whilst receiving personal care. They respected people's privacy and maintained their dignity.

Staff had received training on communication and had discussions during training and team meetings about appropriate ways to communicate with people to ensure they understood what was being said. People told us staff always spoke to them politely and respectfully. Information was also included in people's support plans about how to involve people individually in decisions about their support and ensure they were provided with a choice about the support they received. We saw in one person's care records that they were better able to process information if a limited choice was provided, and therefore staff provided them with two options to choose from rather than an open question. People were also asked who they would like to be involved in decisions about their support, and we saw that these individuals were involved as requested.

Staff supported people at risk of social isolation at key times during the year. For example, at Christmas they

identified who would be spending the day on their own. The staff team went to these people's homes to cook and have Christmas dinner with them.

The management team had been working with a local hospice to provide staff with additional training and information about how to provide good quality end of life care. A member of staff had been identified as an end of life champion and attended in depth training from the hospice staff. This staff member was using their knowledge to support people who required end of life care and also supported their colleagues to increase their knowledge and skills in this area.

Good

Is the service responsive?

Our findings

People, and their relatives, were happy with the level of support they received. One person said in regards to the care they received, "it's perfect." Another person told us they were, "extremely happy. I'm very lucky [with the care they received]." A person's relative said they, "couldn't ask for a better service."

People received the support they required. Assessments were undertaken to identify people's support needs. This assessment identified what people were able to do independently and the level of support they required from staff. Support plans were developed identifying how many visits people required, the length of the visit and what support was to be provided. Detailed information was provided in these support plans about people's needs and they were discussed with care workers.

People's support plans included information about how they wished to be supported and their preferences and routines. Information was also included about people's life histories and their families which enabled staff to know more about the person and their experiences. We saw that support plans also informed staff how people's physical impairments and health conditions affected their independence and mood.

Field care supervisors undertook reviews of people's care package. These enabled staff to review what was being provided and whether it continued to meet people's needs. These were undertaken at regular intervals or more frequently if care workers identified that a person's care and support needs had changed. One person told us they had received a couple of care reviews and this meant they received the level of support they required.

The service offered activities and stimulation in line with people's interests. For example, the service had a dog. People were made aware of this and were able to request for the dog to visit them during their appointments. For example, one person used to be a dog trainer. They enjoyed the interaction with the dog and having planned dog walks as part of the support the service provided them. The staff also participated in the MacMillan cancer support coffee morning. This enabled staff, people and their relatives to get together for support and to socialise, whilst raising money for charity.

The management team set up a text alert system to provide staff with reminders and prompts in order to provide people with the support they required and to promote good practice. For example, in hot weather staff were reminded about the importance of ensuring people had sufficient access to drinks. Prompts were sent informing staff about behaviour that indicates a person may be expressing signs of depression so staff could identify these and report on them for management to take action. Prompts were also sent to remind staff to check equipment at people's homes to ensure it was in safe working order, for example, checking slings for any tears.

People, and their relatives, were given the opportunity to comment on the care they received during their care reviews and also through completion of an annual satisfaction survey. We viewed the findings from the 2015 survey which showed the majority of people stated their care workers arrived on time and stayed the required amount of time. They also said they knew how to contact the field care supervisor and the manager

if they had any concerns or worries.

People, and relatives, were aware of how to make a complaint. The people we spoke with told us they had not needed to make a complaint but they felt comfortable speaking with the office staff if they had any concerns or worries. A process was in place to record, investigate and deal with any complaints received, and the manager liaised with the complainant to assess their satisfaction with how the complaint was managed.

We saw that staff had received many compliments from people, and their relatives, expressing thanks for how the staff supported them and looked out for their health. We also saw a person had expressed thanks for how staff had worked with them and supported them when they were frustrated.

Good

Is the service well-led?

Our findings

People received support from a service that was well-led and had clear leadership and management. Staff told us they were happy working for Chloe Drury Limited and one staff member said, "It's the best service I've worked for…they're very professional." Care workers felt well supported by their supervisor and managers. Care workers said their supervisor was always available and was quick at coming to support them at people's homes if they required it.

The managers and directors were available and we observed staff speaking with them openly. The directors told us they had worked hard to create an open and honest atmosphere and empower staff to voice their opinions. Staff told us they felt able to express their views and that in response to feedback by staff, the management team "take things on board." They told us if they had any questions or concerns, "Someone's always here to talk to." They felt well supported and able to speak with a member of the management team. Staff told us they felt involved in decisions and the management team consulted with them before implementing any changes. The management team told us there was a flat hierarchy and they encouraged all staff to express their views and there was an emphasis on two way communication between care staff and the management team.

The management team told us they were continuing to develop and build on systems to obtain feedback from staff. The office had an 'open door' policy, there was a staff suggestion box and the management team went to meet care workers in the community to obtain their feedback. For example, team meetings were held in different locations to make them more accessible to care workers.

An on call system was in place to ensure an effective service 24 hours a day, seven days a week. This system also ensured senior staff were available to support care workers out of office hours. Staff told us the on call system worked well and they were able to get the same level of support out of hours as they did when the office was open. There was also a second senior staff member on call to help out when required. For example, if due to the concerns raised the on call staff member needed to go and visit a person in their home, a second staff member was available to cover the on call system and provide support to other people and staff.

Staff were asked during the recruitment process to identify the hours they were available. This information was used to allocate staff's rotas, but also to identify which staff were available to cover short notice staffing issues, including sickness and short notice leave. Staff's availability was reviewed regularly so the on call staff knew who to call when arranging cover.

Systems were in place to monitor care workers compliance with people's care packages. This included a mobile system for care workers to log when they attended people's home and when they left, to ensure care workers attended visits on time and stayed for the agreed amount of time. Spot checks were also completed to review the quality of care and support provided, care worker's adherence to internal policies and procedures. These were undertaken regularly to review the quality of service delivery and care records. The management team also reviewed the quality of daily log sheets and medicine administration records when

they were archived at the office. Any improvements required were discussed with individual staff members.

The service worked with the local community and charities to promote homecare services. They had held educational sessions on providing care in people's homes to the Motor Neurone Disease (MND) Association, the Multiple Sclerosis (MS) society and with a local rotary club. This provided people with information about what people should expect from home care and to learn from the community about what they would want from a homecare service. The service had also built links with the Alzheimer's society and all staff were in the process of attending the dementia friends training. These links enabled staff to learn more about how to support people with different diagnoses should the need arise.

The service operated under the Caremark brand. This provided the management team with the opportunity to meet with managers from other Caremark branches to share good practice and ideas to improve service delivery. The Caremark managers met every six months. In addition there was an online forum which the management team could use to obtain advice.

In 2015 the service was awarded the Caremark national achievement award. This award was given to recognise the success the staff had achieved in growing the business and providing consistency in service delivery, during a period of significant change within the agency.

The management team adhered to the requirements of their registration with the Care Quality Commission and submitted statutory notifications about key events as legally required.