English Rose Care 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

This inspection took place on the 29 September and 3 October 2016 and was announced.

English Rose Care Ltd. is registered to provide personal care and support for people living within their own homes. At the time of our inspection there were 24 people using the service, a majority of whom resided within Northamptonshire. People's packages of care varied dependent upon their needs, which included palliative and end of life care. There were 36 staff employed who provided people's 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.

This was our first inspection of the service since they registered with us.

People's safety and welfare was promoted by staff that understood and had received training on their role in protecting people from potential harm and abuse. Safety and welfare was further promoted through the assessment and on-going review of potential risks to people. Where risks had been identified measures had been put into place to reduce their likelihood, which were recorded within people's records and understood and implemented by staff.

Staff upon their recruitment had their application and references validated and were checked as to their suitability to work with people, which enabled the provider to make an informed decision as to their employment. Staff underwent a period of induction and training, which included their being introduced to people whose care and support they would provide. Training provided to staff and staff understanding of their role and responsibilities meant people were supported appropriately with all aspects of their care, which included support with their medicines.

People were in most instances supported by staff who they were familiar with. Staff understood people's needs and were able to note any changes to their health and welfare. This enabled staff to liaise effectively with other professionals involved in the person's care to bring about effective and timely care and support.

Staff understood the importance of seeking people's consent prior to providing care and support. People spoke positively about the staff that supported them telling us staff sought their views about their care and how they wished their care to be provided. Staff were aware of people's rights to make decisions and were able to tell us how they encouraged people to express their opinions on their care and support.

People we spoke with were complimentary about the approach of staff in the delivery of their care and support. They told us their privacy and dignity was understood and recognised by staff and that the approach and caring attitude of staff had a positive impact on them and their daily lives.

People or their family representatives were involved in the initial assessment of their needs. People's needs were regularly reviewed, with their involvement and the support and care they required was detailed within care plans.

People spoke of the positive relationships they had developed with the provider and staff which had enabled them to comment on their care and support, which included their confidence to raise concerns or complaints. Where complaints had been made these had been investigated and the outcome shared with the complainant. We found the provider used information from concerns and complaints to make improvements to the service provided.

We found instances where the provider's policies and procedures were not being fully implemented along with information within the statement of purpose that was not accurate. The provider told us they would take action to address the points raised.

People's views were sought by the provider. The results of the provider's first quality assurance questionnaire however had not been shared with people using the service. This was not consistent with information provided within the introductory letter to people when they commenced a service with English Rose Care Ltd. The provider took action following our inspection. We found the comments expressed within the questionnaires had been acted upon, which had included the employment of additional staff to work in the office to improve communication.

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.

People were protected from abuse because staff had an understanding of what abuse was and their responsibilities to act on concerns.

Risks to people's health and wellbeing had been assessed and measures were in place to ensure staff supported people safely.

There were sufficient numbers of staff available to keep people safe who had the appropriate skills and knowledge. Safe recruitment systems were followed to ensure staff were suitable to work with people who used the service.

People received support with their medicine which was managed safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the appropriate knowledge and skills to provide care and who understood the needs of people.

The provider and staff had an understanding of the Mental Capacity Act 2005 and understood their role in promoting people's rights and choices in all aspects of their care and support.

People were provided with support, where required, to meet their dietary requirements.

People were supported by staff who liaised effectively with health care professionals, to promote their health and welfare.

Is the service caring?

Good

The service was caring.

People were supported by a consistent group of staff, who they

had developed positive professional relationships with.

People or their representatives were involved in the development and reviewing of care plans, which recorded their views about their care.

People were supported by staff that were committed to the promotion of people's rights and who listened too and respected people's wishes.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to receiving a service and were regularly reviewed. Staff knew how to support people and took account of people's individual preferences in the delivery of care.

Concerns and complaints were recorded and used to develop and improve the service provided.

Is the service well-led?

Good

The service was well-led.

Improvements were needed to ensure information produced by the provider was consistently followed and implemented.

The service had a registered manager.

The provider and staff had a clear view as to the service they wished to provide, which was the provision of good quality care to people in their own home.

The provider had a positive professional relationship with those who used the service, their family members and representatives, enabling and providing opportunities for them to comment on the service.

English Rose Care Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 29 September and 3 October 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 the office to meet with us.

The inspection was carried out by one inspector.

We looked at the information held about the provider and the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. We used this information to help us plan this inspection.

To assist us in understanding the experience of people who used the service, we spoke via the telephone with one person and the family members of four people.

We spoke with the provider, five care staff, a team leader, two administrative staff and a care co-ordinator.

We looked at the records of six people who used the service, which included their plans of care, risk assessments and records detailing the care provided. We looked at the recruitment files of seven staff, including their training records. We looked at the minutes of meetings and a range of policies and procedures.

As part of the inspection we sought the views of Clinical Commissioning Groups, as they funded some of the packages of care provided to people by English Rose Care Ltd.

Good

Is the service safe?

Our findings

People we spoke with told us that they or their relatives felt safe when receiving care and support. They said us, "I am confident that [person's name] is safe, as the staff are confident in the care they provide."

Staff were trained in safeguarding as part of their induction so they knew how to protect people. When we spoke with them they were knowledgeable about their role and responsibilities in raising concerns with the management team and the role of external agencies. The provider's safeguarding and whistleblowing policies advised staff what to do if they had concerns about the welfare of any of the people who used the service.

Assessments of potential risks were carried out as part of the initial assessment of people's needs and were regularly reviewed which promoted people's safety. Potential risks identified were supported by a risk assessment, which provided staff with guidance as to how to reduce the risk. For example by the use of equipment to move people safely, such as a hoist or through the adoption of proactive infection control measures when delivering personal care, so as to not compromise people's health and welfare.

Assessments, which were regularly reviewed, were carried out to check the integrity of people's skin to determine whether they were at risk from developing pressure sores. Care plans recorded how staff were to proactively promote the skin integrity of people, by using pressure relieving equipment such as mattresses and cushions and through the encouragement of people to mobilise. In some instances prescribed creams were applied by staff to promote healthy skin. A family member we spoke with told us how staff as part of the care applied the prescribed creams to their relative. A person's care plan directed staff by stating, 'apply moisturiser, especially between the toes.'

Information about people's medicine was included within their care plan, with clear guidance for staff as to their role, where they were required to support people to take their medicine. Staff we spoke with told us they had received training on medicine awareness and that where they were required to prompt people; the medicine had been dispensed by a pharmacist and packaged to record the day of the week and the time the medicine should be administered. The packaging of medicine in this way provided a safer system for staff to follow which promoted safe management of medicine. People we spoke with confirmed staff prompted them to take their medicine, as detailed within their care plan which helped to promote their health.

We found staff's confidence in their ability to respond to unplanned events promoted people's safety and well-being. A family member told us how staff had contacted emergency services when their relative had been found on the floor by staff. Staff referred to the protocol they followed when dealing with unplanned situations. Staff told us how their response was dependent upon the individual circumstance. This showed staff's understanding of people's individual circumstances enabled them to promote their safety.

An assessment of a person's home environment was carried out as part of the initial assessment, which identified any potential risks to people or staff. Where practicable changes were made, with the persons consent, such as the removal of potential trip hazards such as rugs to promote safety. Staff had clear

information about the security and access to people's homes, which included a key safe where people were unable to answer their door. Care plans included information to ensure the person's property was secure when staff departed. This showed the person's safety was promoted whilst enabling staff to gain entry into people's homes.

We found the provider, as part of a person's initial assessment of need, assessed the number of staff required to deliver people's care safely. The number of staff required was detailed within people's care records. We spoke with a care co-ordinator who showed us the system they used when organising the rota to ensure the appropriate number of staff attended each person.

People in some instances received 24 hour support, whilst others received support for an allocated number of hours each day dependent upon their needs. People were provided with the support as identified by their assessment, which included support with personal care, daily living activities and accessing community resources. This was achieved as there were sufficient staff employed who were suitable to work with people, meeting their needs and keeping them safe.

We looked at staff records and found people's safety was supported by the provider's recruitment processes. Staff records contained a completed application form, a record of their interview and two written references. A criminal record check had been carried out by the Disclosure and Barring Service (DBS). The DBS checks help employers to make safer recruitment decisions by providing information about a person's criminal record. This meant people could be confident that staff had undergone a robust recruitment process to ensure staff were suitable to work with them.

Staff upon commencement of their employment undertook training in topics related to the promotion of people's safety. Training topics included the moving and handling of people using equipment, basic life support skills and health and safety. A member of staff who had recently completed their induction told us how the training enabled them to meet the needs of people safely and spoke as to how they found the induction training to be informative. They told us of the procedure they would follow should they arrive at someone's home and found them unwell. This showed that staff were provided with training that enabling them to meet people's needs safely.

We contacted professionals external to the service and asked them for their views as to how the provider promotes people's safety. They provided us with the outcome of their quality monitoring report. This showed they had no concerns relating to the providers ability to protect people from abuse or avoidable harm and evidenced confidence in the provider's recruitment and induction of staff.

Good

Is the service effective?

Our findings

We found the induction and on-going training of staff enabled them to provide effective care as staff implemented the information they had learnt. Staff upon their appointment had an initial induction period. The induction required staff to complete a range of training in topics that were related to the needs of people using the service, which included palliative and end of life care. A recently recruited member of staff told us they had worked alongside experienced staff for two weeks. They said this had provided an opportunity for people using the service to get to know them before they provided the person's care and support themselves.

We looked at the records of staff and found that they were supervised and had their work appraised, which included having their competency assessed to undertake people's care and support. Staff we spoke with confirmed that 'spot checks' (staff were observed periodically in the delivery of care) were carried out by managerial staff to which they received feedback to enable them to improve the care they provided. We looked at 'spot checks' reports which showed they covered a range of areas, such as the effectiveness of staff's ability to communicate and provide the care and support as detailed with the person's care plan.

Staff told us they were supported. They said the provider and staff who were employed in a range of roles were available to answer any queries they had. This included being able to contact the provider or care co-ordinator through the on-call system, which was available 24 hours' a day. This meant people using the service could be confident that effective communication enabled staff to provide care and support, knowing staff were able to seek advice and guidance if needed.

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. Any applications must be made to the Court of Protection; we found no applications had been made as applications were not considered warranted. The provider and staff were aware of the MCA. Staff told us they always sought people's consent prior to providing care and support and was reflected in the guidance provided for staff within people's care plans.

A family member told us how staff promoted their relative's health by encouraging them to eat. They told us how a staff member included strawberries within ice-cream, chopping the strawberries really small to ease swallowing. People's care plans recorded their preferences, which for one person was detailed as, 'for breakfast either Weetabix or cornflakes with warm milk.' Attention to details as to people's preferences supported people's choices and promoted their health and well-being as they were provided with foods they liked, which had been prepared to their individual preference.

Family members spoke positively as to how staff kept them informed about any concerns they had regarding people's health and how staff were proactive in liaising with health care professionals. A relative told us how a member of staff had contacted them having noted that their relative looked unwell and had requested an ambulance. The family member stated the member of staff had taken the appropriate action as their relative upon arrival at hospital had received immediate care to alleviate their symptoms. This showed how action taken by staff promoted effective care for people.

Part of the role of staff was to liaise and share information with other healthcare services, which included specialist nurses, general practitioners, district nurses and hospices. The sharing of information ensured people's care was effective and it reflected people's current needs, which included any changes in their health or welfare. A member of staff described when information was shared how it was considered and questioned to bring about any changes to people's care as, "What is our next step, what are we going to do?" This collaborative approach to reviewing information and people's care enables staff to deliver care that met people's needs.

Staff spoke to us about end of life care they provided and their role in supporting the person and their family. Packages of care for some people were over a 24 hour period, providing on-going care, which enabled people's families to carry out everyday tasks, knowing that the person was being cared for. Staff were knowledgeable about the health needs of people and were able to provide support and care which adapted to meet people's changing needs.

Staff were aware that in some instances people had a DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) as agreed by the person, family and health care professionals. Staff told us in these circumstances anticipatory medicines, prescribed to support people with pain and the relieving of symptom's, was prescribed by health care professionals and was kept within the person's home. Staff understood they were not responsible for their administration, however they told us they would liaise with health care professionals, such as a district nurse, should a person's health deteriorate and they believed the person required support with pain or symptom management. This meant people could be confident that the appropriate health care person was informed so that they could receive the medicine they needed to manage their symptom's and pain.

Good

Is the service caring?

Our findings

People and their relatives spoke passionately about the attitude and approach of staff in the delivery of their personal care and support. People's comments included, "They (staff) have changed my life. Without them I would have been really lost. I live on my own and for me it means there will always be someone there to check on me. They've given me a new lease of life, a reason to stand up and fight, life wouldn't be worth living without them." "The staff are brilliant; my [relative] has accepted them and formed a bond." "Honestly, the staff are really, really good. We're very lucky with them." And, "Staff have a good rapport with my [relative] if ever I visit I hear them all laughing together, he really enjoys and looks forward to their visits."

The majority of people we spoke with told us they were supported by a consistent group of staff which they found had a positive impact on their care and support. Their comments reflected this, "We have continuity of carers, who arrive on time." "The carers are good; we have regular carers who get on well with [person's relative]." And, "We have a good team of staff, because they see us regularly, they can monitor their welfare as they recognise any changes." People told us they were informed when staff knew they would be late arriving at the person's home. People said this didn't happen too often, however they recognised that sometimes staff were late as their previous visit may have found someone unwell, or that staff had been delayed in traffic.

Staff spoke of their commitment to deliver good quality care. Staff were able to empathise with those they supported recognising that people's health impacted on their approach and view of life and their ability to accept their current situation. This meant the approach of staff was to encourage people to maintain their independence. A staff member described this by saying, "We're there to help, not to take away people's independence. We need to have empathy and recognise people's deterioration in their health."

People or their family member was involved in the development and reviewing of their care, which meant they were able to influence the care and support they received. People told us, "We're always involved in the reviewing of the care plan. We're fully listened to when the package of care is reviewed." And, "The care plan and care needs are regularly reviewed, by [provider's name] who visits and seeks our views."

Staff told us how they supported people in a way that reflected things of importance to them. A member of staff told us how someone had requested a visit to a shop to enable them to purchase an item so as they could continue to pursue their hobby. The member of staff told us how they had liaised with the office to re-arrange the person's allocated visits, which had enabled them to take the person to the shop. A family member told us, "They even like our daft dog, and [staff name] arranges his [relative's] legs so the dog can lay on the bed with him." This shows the caring approach of staff has a positive impact on people's lives.

People's care plans instructed staff to always ensure they asked people about their care on each visit to their home, to ensure people had the opportunity to influence their care. Care plans advised staff they should not leave a person's home until they had assured themselves by speaking with the person that there was nothing else the person required. A family member expressed this by saying, "They're [staff] never in a rush, polite and ask you what you want."

People told us their privacy and dignity was promoted and respected. A family member described this by saying, "Nothing they [staff] can do to improve, and they're nice people, not business like but treat with you with respect."

People's care plans provided guidance for staff on the promotion of their privacy and dignity, through consultation and also by their actions when delivering personal care. For example by the use of towels to cover people, thus promoting people's dignity. Staff when we spoke with them, confirmed that information detailed within people's care plans was followed to promote dignity.

Good

Is the service responsive?

Our findings

The provider told us in most instances they were initially contacted by representatives within health, who advised of a package of care they had commissioned for a person within their own home. The provider told us that where they had capacity and the ability to provide the package of care then this was confirmed to the commissioners.

Once agreed with the commissioner's, the provider or their representative contacted the person or their family representative and organised a meeting to undertake an assessment of need to find out what expectations they had as to their care and support. Assessments focused on a person's physical and mental well-being. People we spoke with confirmed that the provider or a representative had undertaken an initial assessment of their needs before they commenced with the service. The initial assessment had taken place within a hospice, hospital or the person's home.

The provider wrote to people following the initial enquiry about their package of care, which included information about the service, including the terms and conditions. The document was referred to as the 'service user handbook'. The provider requested the person signed and returned a copy of the terms and conditions. People's records included signed documentation to show they had consented to answering questions about their care as well as their agreement that the provider or their representatives shared information and consulted with health care professionals to facilitate good care and support. This demonstrated an inclusive approach by the provider to people's care.

Assessments were used to develop care plans, which were person centred, 'Person centred' is a way of working which focuses the actions of staff and the organisation on the outcomes and well-being of the person receiving the service. Care plans detailed how staff made sure people were appropriately cared for and we looked at how this was documented. For example, a person who required oxygen to assist with their breathing, had a care plan stating how staff were to support the person when they were moving about so that they did not become too breathless. Other examples of the provider's commitment to the provision of tailored care, reflected a person's preference as, 'staff to place a person's clothes on the radiator' to warm them.

Care plans were regularly reviewed the frequency of review being dependent upon the needs of people. Records showed how people's care plans had been updated to reflect people's changing needs. For example, one person's review had identified a change in the integrity of their skin, which had resulted in a routine for the application of cream being put into place. A second example was following a change in a person's mental health, which had included a review of the person's care plan as to the approach of staff to encourage independence with all aspects of the person's life.

Care plans reflected the role of staff in supporting people to access community resources. For example one person's care plan required staff to collect them in the evening following a social event. Whilst a second care plan detailed how staff were to support a family in accessing their local Church and community. The review of the person's care plan showed how this was to be achieved, which included supporting a person to

attend a hospice one day a week for social activities. This showed the provider and its staff were able to respond to people's specific and individual needs to maintain contact with the wider community.

We checked complaints records and found procedures were in place, which had been followed where complaints were made. We saw the provider's complaints policy, which provided people and their relatives with clear information about how to raise any concerns and how they would be managed. We found where complaints had been received these had been investigated consistently with the provider's policy and procedure. Action had been taken following complaints, which showed the provider looked to continually learn and improve the service. Complaints had been received earlier in the year about missed or late visits by staff, the provider had identified in most instances the cause was a result of poor communication.

The provider to bring about change had employed additional staff to work within the office; this enabled the care co-ordinator to focus on the rota for staff, planning their visits to people. This had brought about improvements to the reliability of the service. Staff told us how the dedicated 'on call system' had improved communication as they now had confidence that the system meant if they were going to be late arriving at someone's home, this was now communicated to the person.

Good

Is the service well-led?

Our findings

The provider had a statement of purpose. We found information in some instances not to be accurate or implemented as detailed. For example, we found staff upon their recruitment had undergone a period of induction and training programme; however this was not The Care Certificate as stated within the Statement of Purpose. Information within this document stated 'all carers achieve The Care Certificate within the first few months of joining the company'. We found no evidence from speaking with those using the service or their relatives and the staff to suggest that staff having not attained the Care Certificate had had any impact on those using the service. The provider told us they planned to introduce this in the near future.

We found aspects of some policies and procedures were not being adhered to. For example, the recruitment policy and procedure stated, 'people will only be recruited when there is a long-term permanent vacancy….'.however staff recruitment records showed a majority of staff were employed on zero hour contracts. The same procedure stated, that interviews for staff, would involve the manager or immediate supervisor. However interviews were conducted by a member of the office team. The provider told us that all future interviews would include themselves or the registered manager.

We contacted professionals external to the service and asked them for their views, they provided us with the outcome of their quality monitoring report, which showed they had no significant concerns as to the management of the service, its governance, policies or procedures, or issues related to staffing, which included recruitment and training.

People and their family members spoke positively about the quality of the service they received and what it meant to them, their comments included, "I wish to stay in my own home and I wish to goodness they [staff[stay with me, they couldn't be kinder or more helpful." "Nothing they can to do improve." And, "Very happy and lucky they came in; we were against it at first. I wouldn't change anything; I wish we had done it sooner."

People using the service and their family members spoke of the contact they had with the provider and office staff, a majority of people spoke positively, telling us they had regular communication with the provider via the telephone. People's comments included, "I have regular contact with [provider's name] they visit us to review the care plan and ask us how things are going and if there is anything they could do to improve." "Staff go out of their way to communicate with the office, to ensure things run smoothly." A minority of people, however said that when they had contacted the office and left a message, returned phone calls were often not timely.

The provider had identified through their consultation process that communication was an area for improvement. In response the provider had recruited additional staff to work in the office with specific roles, which showed that the views of people were listened to and acted upon. An example of the improvements was the introduction of a dedicated system which logged queries by telephone, to ensure people received a response. Staff spoken with told us this had been well-received by them as they now had confidence that information was now being communicated more effectively. One member of staff said, "Communication has

improved, through the 'on call' telephone system, it's especially good on Saturdays and Sundays, when the office is closed." Minutes of meetings involving the provider, registered manager and staff from the office detailed the changes needed to bring about improvements to communication.

The provider sought people's views about the service when their care plans were reviewed and through the sending out of questionnaires. The provider's letter of introduction, which was sent to people, stated that the summary of the CQC inspection report and the outcome of quality assurance questionnaires accompanied the letter. However we found this not to be accurate. A summary of the CQC inspection report could not be sent as an inspection had not taken place. The provider confirmed that the outcome of questionnaires distributed in February 2016 had not been sent. The provider told us they would take action. Following the inspection the provider forwarded to us a copy of the outcome of the questionnaires sent out earlier in the year, which included the responses to questions asked and actions already implemented and further planned improvements in response to people's comments. The provider informed us these would be sent to those using the service. This was to provide information to people that their views and comments were listened to and acted upon.

The service had a registered manager in post; they were not at the office when we inspected the service. The provider met with us at the office, those we spoke with including people using the service and staff told us they had regular contact with the provider, both in person and by telephone,. They told us the provider was a visible presence who was available to provide support and guidance. A member of staff told us about a difficult situation they had deal with. They told us the provider and other staff had contacted them regularly throughout the day to check on their welfare. The staff member told us, "They [office based staff and provider] have been very supportive, ringing me to see if I am okay." And showed the positive working relationship staff had with the provider.

Staff told us they were supported by the provider, office based staff and in some instances their team leader and that support was provided through supervision, spot checks on their care practices and through meetings. One member of staff told us how they had improved and focused on how they communicated with a person to promote the person's understanding of what was being said. This followed feedback from their line manager. The provider told us they were looking for an office that would be based in Northamptonshire as this would improve opportunities for communication with staff and those using the service as a majority of people lived and worked in Northamptonshire.

Audits had been carried out on the content of people's daily records, to ensure staff were recording information about people's care and support reflective of their care plans. The audits identified where staff were required to improve the information. For example by using specific phrases and words when describing a person's behaviour to ensure people's dignity was promoted.

There was an emergency business continuity plan in place; that would enable the provider to identify and prioritise the allocation of staff to those using the service should an unplanned event occur, such as adverse weather. Information within the plan included the contact details of all those using the service, their next of kin and staff. A risk assessment had been carried out to identify the level of risk to each person using the service, so staff could be allocated to people dependent upon their need. This showed provider had a system in place to ensure people continued to receive good quality care.