Individualised Care Ltd

# Individualised Care Limited

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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 was carried out over two days starting on 26 January 2016. The inspection was announced. Individualised Care Limited is registered to provide personal care and support for people in their own homes. At the time of our inspection 69 people received care and support from this service.

We previously inspected the service on 4 June 2014 when the service was found to be meeting the regulations we looked at.

Individualised Care Limited had a registered manager at the service. 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.

People said that they felt safe with the care and support provided, and that staff were kind, caring and always respectful towards them. Staff understood how to recognise and protect people from abuse and received regular training around how to keep people safe. Staff were not recruited until checks had been made to make sure they were suitable to work with the people that used the service. The staff had previous experience of working in the care sector prior to being employed by the service.

People told us that the staff and management were approachable and if they had any concerns they would be listened to. People said that staff were reliable and there were enough staff to meet their needs. People said that staff holidays or sickness were covered by other staff to make sure that they had consistent support.

People's care records contained the relevant information for staff to follow to meet people's health needs and manage risks appropriately. Staff told us that they were made aware of any changes in people's needs in a timely manner. Care plans and risk assessments were regularly updated, particularly if people's needs changed. People we spoke with were happy with the care and support that they received and were involved in care planning and reviews. People told us they had choice over the support they received and nothing was done without their consent.

We could see from records that that staff responded quickly if someone was unwell and supported people to access other health professionals when needed. People were supported to take their medicine safely and when they needed it, and risk assessments confirmed the level of support people needed.

The provider and registered manager had systems to review care plans and risk assessment to measure the safety and quality of the service. Checks and audits were completed regularly to make sure that good standards of care were maintained. However, not all the records could evidence these were always updated. The registered manager has undertaken to update their quality assurance processes to ensure all records are up to date.

People told us that they felt confident that staff had the knowledge and skills to provide the right care and support. We found that staff had regular refresher training in the main areas to enable them to deliver safe and effective care. However we noted that whilst staff understood the principles of consent and delivering care that was individual to the person, not all staff understood the principles of the Mental Capacity Act (2005).

We have made a recommendation to the provider in relation to staff training.

## 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 had care and support that was safe and protected them from harm and at the times they needed it. Staff had a good understanding of how to keep people safe. They knew their responsibilities in relation to keeping people safe and to manage any risks.

People were supported to take their medicines safely at the times they needed them.

Staff recruitment was safe as references and relevant checks were in place before a person started working with people using the service.

### Is the service effective?

Good

The service was not always effective. Although staff had received training in a number of key areas to ensure they had the skills to care for people, some staff lacked understanding of the Mental Capacity Act (2005).

We saw staff made contact with a range of professionals to maximise the good health of people using the service.

Where needed people had support to prepare meals or with eating or drinking.

### Is the service caring?

Good

The service was caring. People told us staff were kind and caring and showed them dignity and respect in providing care to them.

Staff we spoke with understood the need to support people's cultural and religious beliefs and were mindful of this when providing care, shopping and preparing food for people who used the service.

Staff told us they supported people to be as independent as possible and this was confirmed by people using the service.

### Is the service responsive?

Good

The service was responsive. People's care needs were reviewed every six months or earlier if their needs changed.

Staff approached people using the services as individuals and were able to tell us information regarding their care needs and personal histories. This was confirmed by people using the service.

## Is the service well-led?

Good

The service was well-led. The registered manager was well regarded by staff and she was viewed as supportive and available.

There were systems in place to get the views of staff and people using the service.

There were quality assurance processes in place.

# Individualised Care Limited

**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.

The inspection started on 26 January 2016 and was undertaken over two days. It was completed by 29 January 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 the registered manager would be available. The inspection was carried out by two inspectors for adult social care. At the time of the inspection there were 69 people receiving a service in their own homes.

Before the inspection we reviewed information we held about the service. This included detailed pre-inspection information provided by the provider, previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

As part of the inspection process we met and spoke with four people in their own homes and we spoke with 18 people who received a service on the telephone. We spoke with nine members of staff, and the registered manager.

We looked at 16 care records related to people's individual care needs, nine recruitment files and staff training records for the team. We contacted two health and social care professionals who work with the service for their views on the quality of care provided, and one relative.

Good

# Is the service safe?

## Our findings

People told us they felt safe, one person said, "I feel safe the staff are good for me." People said that they had information from the provider on who to report any concerns to, and they felt confident that any safety concerns would be dealt with promptly.

There were safeguarding and whistle blowing procedures in place. Staff told us they had training in keeping people safe and were able to explain to us how they would identify if abuse was happening and what to do about it, this included who they would contact if they had any concerns. They all knew how to whistleblow and were confident action would be taken if discussed with the registered manager. The registered manager also had a good understanding of her responsibilities in relation to identifying and reporting potential abuse to the local authority. For example, there was an example of a safeguarding alert made by the agency regarding missing jewellery, which was subsequently found.

We spoke with the registered manager with regard to an ongoing safeguarding concern. The registered manager told us how the provider had worked together with the local authority safeguarding team and with other associated professionals to ensure the person involved was kept safe. We were told by the manger they had attended meetings and provided the local authority with all requested documentation. We were able to confirm this by reading minutes of the safeguarding strategy meeting and case conference and by speaking with the local authority safeguarding team.

People told us staff were reliable and turned up on time and the support they received was what they expected and reflected what was in their care plans. People told us staff always stayed for the expected time and made sure that they were alright before leaving. One person told us "my carer is never late and often stays longer than they should."

Staff were able to explain how the office staff e-mailed them before a visit with the care plan and any risks assessments which ensured they were aware of any safety issues before they visited. The registered manager explained there was a system for staff to alert them if they were going to be late or not able to attend a call. The told us that this enabled alternative arrangements to be quickly made to ensure that support could continue to be given. All of the people we spoke with felt that they had consistency with the people that provided the care and support. One person told us "I always get the same carer who is great."

We looked at the staff rota for January. We saw no staff member worked longer than 60 hours providing domiciliary care. The registered manager told us she wanted to ensure staff were not working too many hours as this may affect the care provided. Visits were grouped together in the same locality to minimise travel time between visits, which was usually between 15 and 30 minutes. In line with procedures, staff had to give two weeks notice for annual leave to enable cover to be set up, and for people using the service to be advised. If staff were unwell and unable to attend they were expected to phone the office at the earliest opportunity to ensure cover was provided for their missed visit.

An environmental risk assessment was undertaken of each person's home within 24-48 hours of the care

package starting. This was completed as part of the initial setting up of the service and whenever any changes had occurred. These measures ensured the person and the staff supporting them were not placed at any preventable risk. Staff were expected to report any health and safety concerns to the registered manager so that action could be taken to prevent accidents and incidences occurring. Staff we spoke with were clear that any accidents or incidents had to be reported. We were able to confirm this by reading the provider's accident and incident file. We saw the provider had clear instructions and robust risk assessments and associated action plans to minimise risks in people's homes.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. Care plans and risk assessments demonstrated that the individual had been involved in decision making and this was confirmed by people we spoke to. People told us that they had copies of their support plans in their home and said that their support plans covered all their assessed needs. We were able to confirm this through looking at records in people's homes and reading their respective care plans. People stated that any risks were explained to them and managed well by staff. Staff were able to tell us about people's needs and could tell us how they managed risks associated with people's care and medical conditions.

People told us they were supported to take their medicines safely and on time. We could see from records that staff had received appropriate training. The provider insisted staff could only support people who had their medicines in blister packs, as these ensured the medicines were measured out by the pharmacist in a sealed pack and indicated clearly when they had to be taken. We saw on care files a risk assessment had been completed for people who needed assistance and it referred to their ability to take medicines physically by themselves and with/without prompting. It also covered re-ordering arrangements to ensure there was no interruption to people's essential medicines.

Appropriate checks were undertaken before people began work. All files contained a completed application form and supporting documents to demonstrate training and a pre-employment written test. Files also held a copy of the interview questions and answers. The completion of these documents demonstrated why the individual had been employed or not, and whether they held the appropriate knowledge and skills necessary to do the job. Staff files contained copies of photo identity, evidence of the person's right to work and evidence of record checks with the Disclosure and Baring Service prior to starting work. An appropriate recruitment policy and procedure was seen to be in place. An audit by the local authority regarding recruitment practices in the service in the last year also confirmed effective processes were in place to ensure people were considered safe to work with vulnerable people.

Good

# Is the service effective?

## Our findings

Staff said that they had completed a detailed induction before starting work, which they felt covered all of the essential areas. This induction followed the 'Skills for Care' common induction standards covering safe working practices and included training in safeguarding, manual handling, health and safety and care planning. Records were kept of induction and training received. Staff we spoke with confirmed they felt the induction training was relevant and prepared them to work with the people who used the service.

Staff told us they were well supported and had regular supervision sessions. They also said they were able to call in to the office at any time and there was always someone they could call on for help and advice. Supervision sessions with individual staff were conducted via several means. These included planned face to face meetings at the office, regular telephone contact and annual appraisals. The registered manager or the care co-ordinator also carried out spot checks at people's homes as part of their quality assurance process. They also carried out an investigation with staff in the event of an incident or complaint.

Together these covered areas such as work performance, training needs, organisation and management support. The one-to-one meetings gave workers an open opportunity to discuss any other issues and agree action plans, as required. Spot checks and reviews also checked the capability and knowledge base of individual staff members. This helped to determine where additional support was needed. Conference calling enabled the registered manager and staff from the care team to discuss a topic or change of practice. Records of these calls were kept on staff files.

The training matrix showed learning modules had been completed in areas such as medication, moving and handling, health and safety, communicating effectively, record keeping, infection control and safeguarding vulnerable adults. All of the six support staff we spoke with had achieved a recognised qualification in care. Staff confirmed they had completed a range of learning modules since they started working and gave some good examples of training they had undertaken. For example, staff were well aware of the effects of dementia on a person's memory and ability to carry out activities of daily living and this required great patience of them as care workers to offer care sensitively to people using the service.

The service directly supported people to meet their health needs. Staff told us that if they noticed people's health had deteriorated, they would refer this to their line manager who would assist them to contact their GP or other healthcare professionals as necessary. Records confirmed referrals/communication with district nurses and social workers. Staff told us they would also contact the person's representatives when required.

When a care package was set up for a person the support they required to eat and drink was assessed and agreed as part of their care plan. Staff told us they would report any concerns they had about a person's food and drink intake to the registered manager. The service was not currently working with people who had their food and drink formally monitored for health purposes but we were told they worked in conjunction with allied professionals as necessary and routinely worked with district nurses to prevent pressure areas developing.

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 had received training on the MCA, including the registered manager. People told us they were able to make choices around their care and support. One person said, "staff always ask before they do anything." People who used the service told us that they understood why they received care and had given their consent by agreeing to their care plan. Staff told us that consent was covered with all staff as part of the induction.

We asked the registered manager how the service might work with people who used the service who did not have the capacity to be able to make choices for themselves. The registered manager explained what needed to happen if a person did not have the capacity to make choices. The registered manager told us that people were referred to the local authority or G.P. for an assessment of capacity in the particular area of concern. If the assessment stated the person lacked capacity the provider would speak with associated professionals and family to ascertain how the person might wish their care to be provided. We noted by reading care plans that family members were consulted and where a person lacked capacity family members had signed the consent to care forms.

We noted there was no evidence in people's files of capacity assessments being completed by the service provider or the referring agency. This meant on one care plan the service had noted the person using the service could not make decisions without evidence to support this. This approach did not differentiate between the differing levels of decision making this person could make. For example, a person may be able to tell a care worker what they want to eat or wear but not be able to make a decision regarding an important issue such as their finances or where they live. We asked six staff members how they would support people who lacked capacity to make choices. Whilst they were able to explain how they offered choice and would not provide care without agreement, three were unable to tell us about the principles of the MCA.

We spoke with the registered manager regarding the range of decision making in relation to assessing capacity for people using the service. Medicines administration risk assessments noted capacity and asked a broad range of questions so we were able to understand whether the level of support a person needed to take their medicine. Other sections relating to capacity on the care plans devised by the provider did not contain as much detail on the impact of cognitive impairment on a person when making every day decisions. This could lead to support workers deferring to the views of relatives and not the person they cared for on all matters, not just more important issues.

We raised these issues with the registered manager who undertook to attend further training on the MCA so she can support her staff better in understanding the full requirements of the MCA and update the care records accordingly. She told us conference calls with staff and supervision discussions will also cover the MCA in more detail.

Good

# Is the service caring?

## Our findings

The people that we spoke were happy with the staff and spoke positively about their relationship with them. They told us they felt staff supported them to maintain some independence. They told us about how staff took time to support them to participate as fully as they could in their care and that staff explained clearly before going ahead and carrying out any care tasks. One person who we spoke with told us "this organisation goes one step further to make sure I am alright." Another stated " she [the care worker] cares for me and for what she does."

Staff displayed sensitivity around the difficulties of providing intimate care and the service had a policy of only providing female staff members to women using the service. One staff member told us "the more people get to know you they relax and let you wash them."

Care plans were detailed, holistic and person centred. The care plans showed that the care and support promoted people's choices and independence and staff spoke of the people they provided care to as individuals. People's signatures were on review documents, where they had capacity, and we saw that the registered manager sent out survey questionnaires to people, or family members, to obtain their views on the service and any areas for improvement.

Staff knew what people they worked with liked and didn't like, and knew information about their past and personal histories. The registered manager told us she always encouraged staff "to talk less and listen more." All the staff we spoke with told us they enjoyed their job and felt committed to providing a good quality service to the people they visited.

Staff were able to tell us how they supported people with their cultural and religious needs. Examples included buying culturally appropriate food, adhering to requests to remove shoes entering a person's house and providing care in the way they wanted. One staff member told us they also ensured they turned the TV to the language channel the person preferred before leaving the house.

The staff team reflected the cultural diversity of the community they served and the registered manager told us that where possible she linked up people using the service with carers who spoke their first language.

People told us that they felt all staff treated them with respect and dignity. We spoke with four people in their homes. One told us "my carer always asks if anything might embarrass or annoy me, she gets it right." Staff told us they were mindful of ensuring people's privacy was maintained. For example when helping people wash they ensured their body was covered as much as possible, and they asked family members to leave the room if they were helping a person with any intimate care.

The agency had a policy of not providing care for less than thirty minute slots. This complied with best practice as it has been found that a visit of less than thirty minutes is not conducive to providing a person centred service.

Good

# Is the service responsive?

## Our findings

Care plans were detailed and together with the home care task sheet outlined what care was needed by people using the service. Where information was available they contained details regarding a person's personal history and together with the risk assessments formed a comprehensive set of information regarding a person's needs and the risks identified (to them and within their environment). Care for people was reviewed every six months and more often if required.

People were included in the review as evidenced by the records and there were survey documents on the majority of the case files we looked at. This gave people using the service an opportunity to comment on the current service and highlight any areas for improvement or they would like further assistance with. One person stated "when I started with the agency the manager visited and asked me what I needed and how I wanted things done."

Staff were very clear that any concerns regarding a person's health were communicated to the registered manager and health professionals involved. We saw records that confirmed communications with the district nurse service, local social work teams and GP's.

People told us that they did not have any complaints, but if they had they were confident they would be listened to. We asked three people who received care in their homes and all were able to tell us how they would complain if anything went wrong. They were aware of the complaints procedure and how to raise a complaint. People had information on who to contact including the details of the registered manager and other agencies such as the local authority and CQC. All the people we spoke with knew who the registered manager was and felt comfortable to raise concerns with them or the staff.

We spoke with the registered manager about the handling of concerns and complaints. There had been two formal complaints in the last 12 months. These had been dealt with appropriately and promptly by the registered manager. One related to a safeguarding and as a result of this a new policy and approach was being developed to minimise the likelihood of a repeated situation occurring. The registered manager told us that timekeeping was the most likely concern for people using the service. Most staff members used public transport which meant sometimes people were delayed getting to their next visit on time. The registered manager reinforced to staff the need to phone to alert people if they were running late, and this was confirmed by staff. The registered manager was planning how better to evidence low level complaints that she dealt with quickly and had to date, not recorded. She told us she would be introducing a new system in the coming months.

Staff told us they regularly phoned other staff members particularly if they were providing care that required two people at the same time, to share information and update on their scheduled time of arrival. One staff member told us they regularly met with other staff members they worked with between visits to update each other if there were specific complex issues with a person they were working with.

Good

# Is the service well-led?

## Our findings

The aim of the service was to provide good quality care suitable for a culturally diverse community. In order to achieve this the registered manager told us she emphasised the importance of good quality training and the reinforcing the belief it was very important for care staff not to impose their views on people who use the service.

The registered manager had arranged for six staff to undertake QCF Level 2, seven staff Level 3 and three staff QCF level 5 in Health and Social Care. This was an example of the registered manager providing development opportunities for staff to improve their skills. It also helps to retain staff which provides continuity for the people using the service.

Health and social care professionals confirmed they were able to work in partnership with the registered manager and we found her open and approachable. This was confirmed by people using the service and her staff who also added she was available at all times. Staff felt very supported by the registered manager and the care co-ordinator and appreciated that they were organised, able to be decisive in a crisis and clear about their expectations of the role of care staff.

The registered manager was clear regarding the limits of care her staff could provide, and the safety of her staff was very important. We saw of the four incidents that occurred in the last 12 months, three had resulted in the termination of care packages to the person using the service for reasons of staff safety. Two as a result of challenging behaviour that could not be safely managed, the other as the timing of the package could not be changed and a staff member had been threatened in a specific area late at night.

Staff told us they enjoyed working for Individualised Care Ltd. They could give their views on what worked and what didn't and the registered manager was open to suggestions to do things differently.

The registered manager had quality assurance systems in place to prompt her and the care co-ordinator to book initial visits, remind them to send out survey questionnaires and book timely reviews. Also training was documented as was supervision. However, we found of the care documentation we looked at that two contained care plans that had not been updated following changes in need identified at the most recent risk assessment. We spoke with the registered manager who planned to update the quality assurance process to carry out spot checks on care records to ensure all documents were updated in line with requirements.

The registered manager told us she had introduced 'body mapping' records following an incident when a person had returned from hospital last year with pressure areas. She also planned to introduce a new policy on accepting emergency referrals to include learning from a recent safeguarding that had taken place. This showed us the registered manager was able and willing to learn from incidents and make changes to minimise their reoccurrence.