Care Plus Essex Limited

Care Plus Essex Limited part of Manorcourt Care

Inspection report

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Date of inspection visit: 10 August 2015
Date of publication: 09/10/2015

Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on the 10 August 2015 and was unannounced. This service was last inspected in January 2014 and was found to be meeting all the required standards. Since the last inspection the provider has re-registered as a new legal entity and changed their address. This is the first inspection carried out since these changes had taken place.

The service provides care to people in their own homes either by providing short visits to assist with personal care and, or domestic tasks or to provide live in care.

There was a registered manager in post. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.'

The service was well executed and people were happy with the service they received. The manager was proactive in terms of auditing the service and asking people about their experiences to enable them to address any areas of concern.

The main concern people expressed was about the changes to their regular carers and the timekeeping of their visits. However staff told us they mainly had regular rounds and time to make their scheduled calls. We found that there has been a large number of missed calls since the last inspection which meant we were not assured that people always received a safe service although we did recognise that action had recently been taken to improve the reliability of the service.

Staff knew how to report concerns and were confident in doing so to safeguard people in their care.

Risks to people's safety were eliminated as far as possible as people's needs were assessed and staff were supported through adequate training and had policies to follow. Medicine practices were robust.

The service had robust recruitment processes to ensure only suitable staff were employed. Once staff were employed they were supported through a good induction process to ensure they had the necessary skills to deliver care effectively.

There were systems in place to ensure staff's conduct and practice was of a consistently high standard.

Staff had enough understanding of how to support people and to involve people in their care and seek their consent for different aspects of their care and support.

Staff met and monitored people's health care and dietary needs. They had enough training to enable them to provide individualised care.

The service was responsive to people's individual needs and staff were sufficiently knowledgeable and caring about people. People's care plans reflected people's preferences and choices and people told us staff respected these.

People were consulted about their care and involved in the review of their needs and asked about the service provided to them.

The service was based on an individual assessment of the person's needs and could be flexible as people's needs changed.

Complaints were responded to and there was a clear procedure so people would know how to raise a concern and what they could expect from the service.

This was a well led service with a knowledgeable manager and people who felt the service was flexible and responsive to their needs.

There were audits in place to determine how well the service was being delivered which took into account people's views so the service could be adjusted accordingly.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was mostly safe.

Calls were provided according to people's needs but missed calls meant we could not see that people's needs were always met.

There were robust systems in place to ensure people received their medicines properly but we identified a couple of areas which could be improved upon.

Staff received training and were knowledgeable about how to raise concerns if they suspected a person to be at risk of harm and, or abuse.

Risks to people's health and safety were assessed and as far as possible reduced.

Staff recruitment was robust.

Is the service effective?

Good

The service was effective.

Staff were well supported and trained to ensure they could deliver care and support effectively.

Staff were knowledgeable about people's health care needs and dietary needs.

People gave their consent for care and where they were unable to give consent staff knew how to support them lawfully.

Is the service caring?

Good

Is the service caring?

The service was caring.

People were supported according to their wishes and needs by staff with the right qualities.

People's dignity and independence was upheld and recorded so staff would know how to support the person.

People were involved in their care and decisions about their care and welfare.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and kept under review. The service was measured against how well people's needs were met.

Complaints were responded to and the service adjusted accordingly

Summary of findings

Is the service well-led?

Good

The service was well- led.

The manager was knowledgeable and there were systems and processes in place to monitor the effectiveness and quality of the service.

People using the service and staff felt this was a good service which was well managed and responsive.

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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.

The inspection took place on the 10 August 2015 and was announced. We gave the provider 48 hours' notice in line with our methodology and to enable the provider time to arrange domiciliary care visits on our behalf.

The inspection was undertaken by two inspectors. Before the inspection we looked at information we already held about the service including the last inspection report, and information provided from or about the service. We visited six people using the service and spoke with three relatives. We spoke with nine staff, including care staff and senior staff. We met the regional manager and the registered manager. We looked at eight care plans and other records relating to the management of the business including audits, and staffing records.

Requires improvement

Is the service safe?

Our findings

The service was well organised and there appeared to be enough staff to meet people's needs with a large percentage of part time staff, who were flexible to pick up additional work. Rotas were issued to staff and people using the service. No one we spoke with raised concerns about the support they received although people did tell us that visits ran late occasionally. The manager told us recruitment was challenging but retention of staff was good. In addition to a full time manager there were care coordinators, team leaders and training officers who all had clear lines of responsibility; some were fairly new to their post but said they were well supported.

We looked at rotas and how visits were scheduled. Most rotas showed some gaps throughout the day which would enable staff to provide support to people flexibly and catch up if they were running late or pick up additional calls. We were concerned that people did not always receive safe care as records showed in 2014 there were 21 recorded missed calls. We did not review all of these to see the reasons but some gave an explanation as, 'missed off the rota.' We spoke with the manager who told us that things had been tightened up and staff holiday allocation was stricter, and staff sickness was monitored through the human resources department. The manager said missed calls were managed through the team brief, where changes to rotas were discussed in the weekly brief and investigations were completed for missed calls to establish why these had occurred. Despite improvements, four missed calls had been logged for 2015.

We asked how they tracked their staff and they said through monitoring daily records, time sheets and rotas. They also used spot checks and as part of their quality assurance process they asked people about their visits and timeliness of these.

We asked people about their medicines. One person said "Staff prepares my medication, just in the last few weeks. I take it myself." A relative told us "The staff are very good at administering medication. I feel confident. The chart is always completed."

We identified a potential concern regarding medications. We saw several people had their medicines/food through a percutaneous endoscopic PEG tube. Staff received training and we saw training certificates issued by the supplier of the pump and feed. However there was no further assessment of staff's competence once they had received the initial training which was class based. One staff told us they had the training but did not as yet support people who required this level of support so were not applying in practice what they had learnt. The training officer said they would be supported by staff who were familiar with the process but it is the responsibility of the trained professional to sign staff off as competent. This was highlighted in their own medicines policy.

Staff also told us that the timings of calls could be difficult in terms of medicines. For example they said where people had more than one eye-drop there should be 15 minutes between eye drops but some calls were only 15 minutes. The manager said that if people needed a longer visit due to a change in need this would be provided and authorisation from social services sought when they were financing the call.

We looked at the medicines policy which was comprehensive and clearly detailed the different levels of support people might require. It had a review date of February 2015 but there was no evidence that it had been reviewed. We looked at medicine audits and these were robust.

Care plans contained information about people's medicines and a risk assessment was in place. The manager told us this applied to everyone whether or not their medicines were administered by them or not. Medicine recording sheets, (MAR) were completed correctly with no unexplained gaps. However, there was not an explanation about what the medicines were for and one person did not have a completed risk assessment. The manager told us this would be addressed. People commented that staff wore gloves and aprons when applying creams. A body map was included to indicate where creams should be applied and the MAR completed correctly. Daily notes were completed and signed.

We spoke with staff who told us they administered medicines to people. They said before they administered medicine they received full training including how to administer eye drops and ear drops. They told us how they were observed to ensure they were competent to administer medicines safely. Spot checks on staff medicine competencies were at least six monthly, more if concerns were identified.

Requires improvement

Is the service safe?

People told us they felt safe in the company of staff. They had access to information about safeguarding procedures in their service user guide.

One person said, “I feel safe using the service. We always have a good laugh.” We saw a clear record for complaints and safeguarding concerns which had been recorded, investigated and dealt with appropriately by the service.

Records showed us that staff received training on how to safeguard people and raise concerns when required. We spoke with staff who showed a good understanding of what constituted abuse and how and to whom they should report concerns . Staff told us what they documented and what information they would pass on to the manager, or the care coordinator and team leaders. They were confident that matters would be dealt with.

Staff were issued with a handbook and summary of policies and procedures they would need. A safeguarding policy was available to staff and the manager said this would be revisited with staff at their supervisions and at team meetings to ensure staff had a sufficient understanding of how to protect people.

Care records showed that checks were made on people’s homes to ensure that they were a safe environment for people to receive care. Appropriate risk assessments were in place; such as an assessment of the home environment; falls risk assessment, moving and handling risk assessment and a medication risk assessment. The initial assessment of the person’s needs highlighted the person’s wishes and any risks associated with the person. This related to previous history and any medical conditions they might have. This was kept under review. Risk assessments on the persons home included personal information such as does the person have any allergies or does the person have pets on the premises. They were sufficiently robust to enable the service to plan and deliver the care safely.

We looked at staff recruitment files and these were of a good standard. We saw that potential new staff were interviewed by at least two people using a standard format and interview questions based around essential criteria. Before employment staff’s credentials were checked to ensure they were of good character, had no relevant convictions which would make them unsuitable to work with people in a care setting and that they had a checkable work history, including references. Personal identification was on file including eligibility to work in the country.

Good

Is the service effective?

Our findings

One person using the service told us, “The staff are well trained. They work well as a team.”

Staff told us they were supported in their role. The organisation had its own training team and training suite. New staff completed a one week induction on the premises. Their initial training included relevant training for example: moving and handling, infection control, food hygiene, medication, Mental Capacity Act & Deprivation of Liberty Safeguards, safeguarding, and dementia. There was a schedule of when training required to be updated and this was done, some annually some less frequently. Staff were supported and encouraged to do relevant care qualifications. Staff also received additional training as appropriate around the specific needs of people using the service. Staff gave us examples of additional training they had received which included: Parkinson’s care, diabetic care and dialysis.

We spoke with staff who told us, following on from their initial weeks training, they then went out with more experienced staff until confident to work on their own. One staff member said this had been for a period of about two weeks. They told us they had an induction booklet they worked through and this was signed off by the staff member responsible for their induction.

Staff completed a three month probationary period in which their performance was monitored through spot checks. These were planned every other month; staff also had 1-1 supervision and an annual appraisal of their performance and training requirements. Medicine spot checks took place to assess staff’s competency to administer people’s medicines safely. There were also quarterly team meetings and a newsletter. Staff told us during the spot checks they were observed delivering care and checked to ensure they had the right equipment and arrived/left on time.

Staff records showed us their training was up to date and refreshed at regular intervals to ensure staff’s knowledge was current.

The manager had a good understanding of capacity and consent and said that if people were unable to consent then further advice/assessment would be sought via the Local authority. The Mental Capacity Act 2005 sets out legislation on how people without capacity to make decisions about their care and welfare should be protected. People were asked for their consent before staff assisted them with their care and, or treatment such as medication administration. Staff told us they had training around mental capacity and the legal aspects of this and had a sufficient understanding. Assessments included involvement with the person and whoever knew them best and where people lacked capacity health care professionals were involved.

People’s health care needs were documented with an explanation of how they should be met. One person told us they were concerned that staff were late in the morning because they were diabetic and needed their breakfast on time. This was not recorded in their care plan and staff spoken with were not sure whether they were diabetic or not. They agreed to confirm this urgently and discuss with the family so it could be rectified immediately and ensure the person had their breakfast in good time. Staff had the training, skills and understanding of people’s needs and were matched accordingly. For example one staff told us they had not done end of life care so was not required to support people who were end of life unless they received the training first. We met with one person who had variable health care needs and then saw that there were regular reviews of their needs and this involved other health care professionals as required.

Where people needed assistance with meal preparation or to ensure people ate and drank enough for their needs, this was documented and monitored through care records. Referrals to dieticians via the GP were made if necessary.

Good

Is the service caring?

Our findings

The service ensured that people received a service which they were happy with and one that upheld people's dignity and choice. One person told us, "I have had a male member of staff a couple of times. They ring and check I am happy with that." They continued to say, "Staff explains what they are doing. They are respectful." A relative told us, "They seem to be very kind to Dad."

Another person told us, "The staff are respectful. They explain what they are doing and ask for my consent. One person said, "I have asked to have a female and this is fulfilled." One person said, "They have real empathy, they bring in the sunshine."

Overall, people and their relatives commented very positively about the staff and the service as a whole; they told us they were involved in their care and kept informed and their consent asked for. People and their relatives also told us that staff were kind and respectful.

People said that staff were well trained and generally on time. People were able to express a preference about the gender of staff and that they were normally introduced to new staff. However, two people said that staff were sometimes late; and two people told us that they were not always informed about staff changes.

We spoke with staff who spoke positively about the people they supported. One staff told us how the company had evolved starting from small beginnings, as a partnership and eventually sold to a bigger consortium. Staff said they got to know people really well and were able to provide personalised, compassionate care and even though the service had grown it was still small enough to provide continuity of care. Staff told us that principles of care were covered as part of the induction. They said they were supported through training around the individual needs of people using the service which enabled them to provide personalised care. Staff said end of life care was important and enabled people to be cared for appropriately at home if they wished and staff said they were supported to do this.

Care plans recorded how staff should meet people's individual needs and included information about people's past, relevant histories and any preferences they had in relation to their care and support. Staff told us they knew what people's needs were and had enough information to help them give care and support effectively. Care plans included things like, 'what makes me worry, or anxious.' This then told staff how they could support the person effectively and reduce their anxiety and distress. Care plans also told us what people could do for themselves and what they needed help with so care could be provided appropriately and help to promote people's dignity and independence.

The service had a postal survey which they used to obtain people's feedback. These included questions about the support they received and if they were happy with this. This helped the service monitor the quality and effectiveness of the service it provided. In addition to this there were spot monitoring checks carried out on staff during their visits to people to ensure staff were providing good care. There were also face to face reviews with people to ensure the support provided remained appropriate to their needs.

Good

Is the service responsive?

Our findings

One relative told us in the company of their family member how the service supported them. They said “We have a whole variety of staff coming out. They are fine. There is a weekly schedule sent out, we know who is coming. I am happy with the time keeping.” One person using the service told us, “It’s going well so far. The people are all quite nice.”

Staff recorded visit times in the daily notes. These sometimes fell short of the 30 minute funded visit time but it was difficult to know if this was a consistent theme. One person commented that staff regularly stayed longer than their allocated time. Staff told us that travel time was not accounted for, however staff were allocated people that lived very close together and that travel time was taken into account. Staff also told us that they tended to visit the same people which meant they were familiar with their needs and knew where locations were which meant they could arrive promptly. The only exception to this was holidays and weekends when there were less staff working. However staff said it usually worked well.

The manager confirmed that they carried out an assessment of need before accepting any new people so they could be assured they could meet their needs and had sufficient staff to cover the care calls. At this initial assessment the times of the visits were agreed with the service trying to closely match the wishes of the person. They operated half an hour each side of the agreed time which gave them some flexibility and allowed for delays.’ A four weekly review was completed at the beginning of a service being provided to make sure everything was working well. An annual review then followed. Telephone reviews also took place periodically.

Staff told us they usually had enough information to meet people’s needs and care plans were up to date. When visiting a new person they said they were given basic information before arriving. Care plans were clear, structured and easy to follow. However, there was limited information about people’s life histories or preferences and the manager acknowledged that in some cases this could be improved. Care plans provided a reasonable overview for staff of the care and support to be provided at each visit. They had all been reviewed within the last year which the provider told us was their standard. One person told us that their care plan was reviewed at least every three months because of their medical conditions. This was not supported by records held in their home and the manager confirmed this would be addressed.

Daily notes were up to date and provided a brief overview of the support provided. They were written in a respectful way and did demonstrate that the care was provided in line with the care plan.

People told us that the service was flexible and that the manager was receptive and could respond to requests such as an increase to the care hours provided or a change in date.

The provider had a complaints procedure which was included in the service user guide held in people’s homes.

One person told us,” “I did have a complaint once. I phoned the office and they sorted it out.”

People we spoke with told us they did not have any complaints and would be able to raise any issues with any of the staff. We observed a person raise an issue in an open way and it was responded to with concern and respect.

We saw the complaints procedure gave information about who to complain to and how quickly complaints would be resolved. It also said it was available in different formats to suit people’s individual needs. Complaints were logged so we could see when they were made, when they were responded to and what actions the service had taken to resolve them.

Several people told us that not all the staff were easy to communicate with where English was not their first language but we did not follow this up at the time. However we did see robust recruitment processes which assessed staffs suitability for the role of carer

Good

Is the service well-led?

Our findings

People and their relatives spoke very highly about the service as a whole and the office staff were commended for being cheerful, friendly and approachable. One relative told us, "When staff are sick they let us know. I keep in communication regularly." One person using the service told us, "They are the best company in the area. The Manager is very receptive" A relative told us

"They have met our needs and expectations." By this they told us the service could be altered according to the needs and wishes of their family member. Another said "The service is well managed. They are responsive to questions and alterations. They can be flexible about changes."

The manager told us they were well supported by other managers in the group and the Regional manager was there on the day of our inspection to support the manager. The manager said they met with other managers at least six weekly to share ideas and good practice.

People using the service and their relatives told us that they were able to access the service out of hours when required. There was an established out of hours system and staff said they felt supported and if they needed to contact a senior this was straightforward. People have information about the service and were able to show us. This included a care folder which had all the relevant information such as how to contact the service out of hours and the complaints procedure. A service user guide and the provider's statement of purpose was available (but not updated to include the new office address).

Some people commented that they liked to receive their weekly staff schedule in the post so they knew who would be coming. Some people commented that they did not like last minute changes particularly when they were not informed.

The service had a quality assurance system which meant they sought people's views about how the service was provided to them and if they were happy with everything. This enabled the service to make improvements where required. People visited confirmed they had received and completed questionnaires. In addition to an annual survey, senior staff carried out spot checks on staff and conducted annual reviews of people they visited, sooner if necessary. We saw evidence that daily notes kept in people's homes were transferred back to the office each month along with the medication record. This was so they could be audited to ensure people's needs were met according to their plan of care and staff were staying the correct amount of time. Medication errors could also be identified and we saw that audits picked up gaps in the medication recording sheets which were then used to identify the members of staff delivering the care. The service then dealt with this through additional supervisions, spot checks of staff performance and additional training as required. This meant they had effective systems in place to measure the quality of the service they were providing.

We saw that standardised audits were carried out on different aspects of the business to ensure it was being managed effectively and safely. Complaints, safeguarding's and compliments were collated and acted upon. The manager conducted their own monthly audits and had a firm understanding of the different elements of the business and felt well supported whilst maintaining autonomy to manage the business. They told us there was lots of reflective practice and this was brought into team meetings, so they were a learning organisation reflecting on mistakes to bring about positive changes.

The manager told us how they tried to engage with the local community. They said they had been involved with dementia action alliance which was involved in raising awareness and knowledge about dementia and its effect on individuals and its prevalence in the community. The manager had completed a train the trainer, to become a dementia coach which meant they could help other staff in the best way of supporting a person with dementia. They had also encouraged other staff to take part in this and also distant learning courses such as end of life.