Take A Break Warwickshire Limited

Take-a-Break Warwickshire Limited

Inspection report

Canterbury House, Exhall Grange Campus
Easter Way
Coventry
West Midlands
CV7 9HP

Tel: 02476644909
Website: www.tabw.org.uk

Date of inspection visit:
06 July 2016

Date of publication:
01 August 2016

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?	Requires Improvement

Summary of findings

Overall summary

This inspection visit took place on 6 July 2016 and was announced. The provider was given two days' notice of our inspection visit to ensure the manager and care staff were available when we visited the agency's office.

The service was last inspected in July 2014 when we found the provider was compliant with the essential standards described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Take-a-Break is a registered charity and domiciliary care agency providing 'respite' care for young adults and children in their own homes and in their local community. People who used the service were offered support on a 'respite' basis only; this meant the charity provided support to people on short term contract arrangements. People received a range of support through a number of hours per week. On the day of our inspection visit the charity was providing support to 13 people with 14 members of care staff.

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. We refer to the registered manager as the manager in the body of this report.

People felt safe using the service and there were processes to minimise risks to people's safety. These included procedures to manage identified risks with people's care and for managing people's medicines safely. Care staff understood how to protect people from abuse and keep people safe. The character and suitability of care staff was checked during recruitment procedures to make sure, as far as possible, they were safe to work with people who used the service.

Care staff received an induction when they started working for the service and completed regular training to support them in meeting people's needs effectively. People told us care staff had the right skills to provide the care and support they required. Support plans and risk assessments contained relevant information for staff to help them provide the care people needed in a way they preferred.

Care staff were supported by managers through regular meetings to discuss their performance and development. There was an out of hours on call system in operation, which ensured management support and advice was always available for staff during their working hours. The manager understood the principles of the Mental Capacity Act (MCA), care staff respected people's decisions and gained people's consent before they provided personal care.

There were enough care staff to ensure people were cared for safely. We had mixed feedback about whether there were enough staff to support people as they wished. Staffing levels were determined based on short term 'respite' breaks. This meant people were not put at risk if staff were unavailable to deliver the service.

People told us care staff were caring, kind and knew how people liked to receive their care.

People told us communication could be improved regarding staffing levels and their agreed packages of care. The manager and provider was acting to improve their service by reviewing existing care packages and what they could offer to people. Staffing levels had recently been changed along with care packages.

People knew how to complain and information about making a complaint was available for people in their homes. Care staff said they could raise any concerns or issues with the managers. Identified concerns were acted upon by the manager and provider.

There were systems to monitor and review the quality of service people received and to understand the experiences of people who used the service. This was through regular communication with people and staff, spot checks on care staff and a programme of other checks and audits. Where issues had been identified, the provider acted to make improvements.

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 felt safe with care staff. People received support from staff who were of good character and understood the risks relating to people's care and supported people safely. Care staff understood their responsibility to keep people safe and to report any suspected abuse. There were enough care staff to support people safely.

Is the service effective?

Good

The service was effective.

Care staff completed training and were supervised to ensure they had the right skills and knowledge to support people effectively. The managers understood the principles of the Mental Capacity Act 2005 and care staff respected decisions people made about their care.

Is the service caring?

Good

The service was caring.

People were supported by care staff who they considered caring, kind and who respected people's privacy and dignity. People received care and support from consistent team of care staff that understood their individual needs.

Is the service responsive?

Good

The service was responsive.

People and their relatives were fully involved in decisions about their care and how they wanted to be supported. People's care needs were assessed and people received a service that was based on their personal preferences. Care staff were kept up to date about changes in people's care. People knew how to make a complaint and the management team responded to these and acted to improve the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People were satisfied with the quality of care they received from care staff and said they were able to contact the office and speak to management if they needed to. However, some people told us the communication with the management team could be improved. Staff were supported to do their work effectively and felt able to raise any concerns with the management team. The manager regularly reviewed the quality of service provided.

Take-a-Break Warwickshire 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 visit took place on 6 July 2016 and was announced. This service was inspected by two inspectors. The provider was given two days' notice of our inspection because the charity provides care to people in their own homes. The notice period gave the manager time to arrange for us to speak with them and staff who worked for them.

We reviewed information received about the service, for example the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority commissioners to find out their views of the service. These are people who contract care and support services paid for by the local authority. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We found the PIR reflected the service provided.

Before our inspection visit the provider sent us a list of people who used the service. We sent questionnaires to 12 people or their relatives, 24 members of staff and 8 community professionals. We received responses back from 2 people, 3 staff and 4 community professionals.

We contacted people who used the service and their relatives to obtain their views of the service they received. We received two responses from relatives of people who used the service on behalf of their family members.

During our inspection visit we spoke with two care co-ordinators, the registered manager and the operations director. Following our inspection visit we contacted 5 care staff via email to gather their feedback about the service, we received two responses.

We reviewed three people's care records to see how their care and support was planned and delivered. We checked whether staff had been recruited safely and were trained to deliver the care and support people required. We looked at other records related to people's care and how the service operated including the service's quality assurance audits and records of complaints.

Good

Is the service safe?

Our findings

All of the people we spoke with told us they felt safe with the care staff that supported them. All of respondents to our survey told us they strongly agreed that they felt safe with staff who provided care to them.

People were supported by care staff who understood their needs and knew how to protect people from the risk of abuse. Care staff attended safeguarding training regularly. This training included information on how they could raise issues with the provider and other agencies if they were concerned about the risk of abuse. Care staff told us the training assisted them in identifying different types of abuse and they would not hesitate to inform the manager if they had any concerns about anyone's safety. The provider notified us when they made referrals to the local authority safeguarding team where an investigation was required. They kept us informed of the outcome of the referral and any actions they had taken that ensured people were protected.

The provider's recruitment process ensured risks to people's safety were minimised. The manager checked care staff were of a suitable character to work with people in their own homes. Staff told us and records confirmed, they had their Disclosure and Barring Service (DBS) checks and references in place before they started to support people. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services.

There was a procedure to identify and manage risks associated with people's care. An assessor conducted an assessment of people's care needs that identified any potential risks to providing their support. Risk assessments were up to date, were reviewed regularly and included instructions for staff on how risks to people could be minimised or managed. For example, one person who was at risk of becoming unconscious when having a seizure, had a risk assessment in place for managing their condition which instructed care staff on how they should act in this type of emergency.

In another person's risk assessment it described how the person became upset and agitated by loud noises and busy crowded places. The risk assessment described how care staff could assist with reducing the person's anxiety by singing. It also described situations care staff should avoid to minimise the risks to the person. Care staff we spoke with knew people well and could describe the actions that they would take to minimise risks.

We looked at how medicines were managed. Most people we spoke with administered their own medicines or their relatives helped them with this. Care staff were contracted to administer medicines to people on an 'as required' basis only. This meant staff were only administering medicines when needed, for example, following an epileptic seizure. We found there were detailed instructions for care staff to follow on when they should administer medicines.

Care staff told they received training in the 'effective administration of medicines'. This included checks by

the trainer on staff's competency to give medicines safely. Care staff recorded in people's records that medicines had been given and signed a medicine administration record (MAR) sheet to confirm this. Completed MARs were checked by senior staff during spot checks and when they were returned to the office every month for auditing. These procedures minimised the risk of errors being made.

We received mixed feedback from people and staff regarding whether the staffing levels at the agency ensured people were cared for as agreed in their care package. One relative told us there were usually enough staff. Other people told us there were not enough staff employed by the agency to cover all their scheduled calls. A relative told us, "I think the agency lacks reliable, consistent staff. I was previously supported during weekdays and weekends, but now due to inadequate staff they are only able to provide one carer for a Saturday only." Another relative said, "It's getting better, but sometimes calls are not always fulfilled."

The manager explained the charity had recently conducted a review of care packages and staffing levels. Following the review, they had reduced the number of people they supported and their staffing group. This was because over time, original packages which were set up as short term breaks had been extended, some people now required regular permanent support. This regular permanent support was outside the charity's original remit. The review had taken place to reduce care packages in line with the charity's goal of only supporting people for short breaks. Those people who needed care outside this had been referred to other appropriate domiciliary care agencies and the appropriate notice had been provided to the local commissioning authorities. Staffing was arranged to meet the needs of people on short term breaks and was not designed to offer regular care visits in people's homes.

Because staffing levels were determined based on short term 'respite' breaks, this meant that when staff were not available to deliver the service people were not put at risk. One member of care staff told us, "Most of the time we do not have an issue with staffing, however during busy holiday periods when staff are more likely to take holidays, this is when we occasionally struggle. We do sometimes have an under delivery of service but try to make up the hours." The manager explained, "When staff are off sick scheduled calls might not happen, as there is no risk to the person receiving the service, allocated hours are re-scheduled for another time."

Good

Is the service effective?

Our findings

People told us care staff had the skills they needed to support them effectively. One relative commented, "The staff member we currently have is really good."

The provider had a recruitment process in place to recruit care staff who had the right skills and values to support people. Care staff told us they received an induction to the job when they started work. This included working alongside an experienced member of staff, and training courses tailored to meet the needs of people they supported. One member of staff described their induction saying, "We received training in specific skills, according to the people we support. For example, epilepsy training." The induction training was based on the 'Skills for Care' standards and provided staff with a recognised 'Care Certificate' at the end of the induction period. Skills for Care are an organisation that sets standards for the training of care staff in the UK. This demonstrated the provider was following the latest guidance on the standard of induction care staff should receive.

Care staff told us in addition to completing the induction programme, they had a probationary period and were regularly assessed to check they had the right skills and attitudes required to support people. Records confirmed care staff had a probationary period before their employment was confirmed and received regular training to keep their skills up to date and provide effective care to people. This included training in supporting people to move safely, medicine administration and safeguarding adults and children.

Where care staff were required to support children, specific training was delivered in how staff should support younger people, for example, first aid for children. One member of care staff told us, "When I started I received lots of training. I still receive lots of training and refreshers…I am very happy with my training." The provider had an onsite training room and a senior member of staff or the manager supported care staff with their training needs. In addition the provider used external professionals to train care staff with clinical and complex care skills. One community professional commented, "The managers ask for support and we help to train their staff to carry out the individualised care for children with complex care needs. This includes completing a long and involved competency on line, per child, per skill. Managers allow staff time to do so. This ensures best care for the children."

Care staff told us they were encouraged to complete a nationally recognised qualification in care. Records confirmed that more than 50 per cent of staff had completed a recognised qualification in care. Information in the PIR stated the provider made sure all staff had an opportunity to continue with their professional development.

Care staff told us they had regular meetings with their manager to make sure they understood their role and spot checks (unannounced visits) to make sure they put this into practice safely. The manager said, "We conduct regular meetings about performance when needed, we also conduct yearly appraisals."

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 adults 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. Adults 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. Where services provide care for children both parents and children should be consulted about their care needs, parents are required to provide consent for care and treatment up to the age of 18.

The manager understood their responsibilities under the MCA. They told us the agency supported younger adults who could not make all of their own decisions. There were processes in place to assess people's capacity to make their own decisions. However, it was not always clear from care records which decisions people could make for themselves. We asked the manager about this who explained care records and consent records were due to be updated to reflect this information more clearly. We were confident people were being consulted about making their own decisions. One relative told us how their adult relation was involved in decisions about their care saying, "We sit down and make plans with them. For example, [Name's] care will increase from 2 hours to 10 hours during the school holidays. A meeting will be held to decide how [Name] would like to spend this time." A care co-ordinator explained, "Where a person's wishes differ from their family members' the person's wishes are paramount."

We saw where people lacked the capacity to make certain complex decisions, for example how they managed their finances, they had somebody who could support them to make these decisions in their best interest such as a relative. Where the charity was providing support to children, care records showed relatives had consented to their child's care and support.

Care staff completed basic training in the MCA through their induction procedures and knew they should assume people had the capacity to make their own decisions, unless it was established they could not. Staff knew they should seek people's consent before providing care and support.

Care staff and people told us Take-a-break worked well with other health and social care professionals to support people. This was confirmed by local community professionals who worked with the agency to support people.

Good

Is the service caring?

Our findings

Everyone told us the care staff treated them with kindness, and staff had a caring attitude. This was confirmed by the respondents to our survey with 100% strongly agreeing that staff were caring and kind. One relative said, "Oh, yes. They are very caring." They added, "The staff have built up good relationships with [Name] and they trust them."

Care staff told us they enjoyed their work which meant people who used the service benefited from their positive attitude. One staff member told us, "I thoroughly enjoy all aspects of my role at Take-a-Break as I feel as though I can make a difference to children and families lives."

People told us staff knew them well and understood their individual needs. One relative said, "[Name's] current care team are really good with them, they know every little thing about them."

People were cared for by a consistent team of care staff who knew people well. This was because staff were introduced to the person and learnt about their needs from existing care staff before supporting them alone. Care staff told us when starting to support someone they were taken to meet the person at their home. A relative told us, "When new care staff start the experienced staff teach them all about [Name]." One staff member commented, "When starting with a new person staff are usually accompanied by the co-ordinator for a home visit, this is where you meet them and their families. " They added, "Alternatively, we meet the customers via a group setting or shadow members of staff who already know the customers well."

Everyone told us the care staff treated them with respect and dignity. This was confirmed by the respondents to our survey with 100% strongly agreeing. Comments included; "Staff speak to [Name] a respectful way", "I have never had any problems; they have a positive attitude to disabled people."

People had different communication needs depending on their medical conditions and their individual support requirements. Care records were in place to instruct staff on how each person should be communicated with, to ensure people were able to express their wishes around their care. For example, in one person's care records we saw the person had specific communication needs, care staff were instructed to use a range of techniques including using pictures, slower speech, making eye contact and being calm and patient when speaking with the person.

People told us they were involved in making decisions about their care. This included making everyday choices about what they wanted to do and through meetings with their care co-ordinator and had frequent regular reviews of their care needs. Comments included; ""They ask them what they want to do", "Frequent reviews take place."

Information was provided to people in a range of formats by the provider, at people's request. For example, information could be provided in an 'easy read' format using large print and pictures to make them accessible to people. Documents provided in this way gave people the opportunity to take part in meetings and provide feedback to the provider, appropriate to their abilities to communicate. This helped people to

maintain their involvement and independence.

People told us staff upheld their privacy wherever possible. One relative said, "They [staff] shut the curtains and tell them discreetly if they are taking them to the toilet." One care staff member told us about their values when they supported people saying, "I feel the people I support are all treated with dignity, this is a priority. During personal care we make sure dignity is kept throughout the session."

Good

Is the service responsive?

Our findings

People told us care staff were responsive to their individual needs and wishes. This was because care staff listened to what people wanted and acted in response. One relative told us, "Nothing is too much trouble."

People told us their support needs had been discussed and agreed with them when the charity began supporting them. Their care package was based on their individual choices about what activities they wanted to undertake in their allocated hours. People told us that they were supported to go out in their local community, as this formed part of the service Take-a-Break provided. Care staff encouraged and supported people to follow their interests and take part in social activities. Activities included swimming, the cinema, visiting the park and going to a day centre. One relative told us staff took their relative out in the local community as they wished, but also supported them to practice their independent living skills.

The care records we reviewed provided care staff with information about the person's individual preferences and how they wanted to receive their care and support. For example, people's likes and dislikes were recorded. In one person's care records we saw what food they enjoyed and what activities they liked. Other people's records showed they liked to go for walks, to sing, and their favourite TV shows.

Staff were allocated and matched to support people as they wished. For example, when people wanted to be supported by staff to go swimming, the care co-ordinator allocated staff that could swim. People also made choices about which staff members they preferred, for example, one person had chosen younger staff members to support them.

Care staff told us they had an opportunity to read care records regularly and daily records at the start of each visit. They also had the opportunity to get to know people before they supported them. One member of staff told us about the handover procedure when they started supporting someone new saying, "The handover procedure is shadowing other staff members who already know the person. This is usually done over a period of weeks. It gives the key information staff need to know about someone."

The care records also included 'handover' information (daily records) from the previous member of staff, which updated the following member of staff with any changes since they were last in the person's home. Care staff explained the daily records supported them to provide effective care for people because the information kept them up to date with any changes to people's health or care needs. One staff member commented, "Records are kept as up to date and are checked regularly."

Care staff told us they referred any changes to people's care to the office staff or managers, and plans were reviewed and updated so they had the required information to continue to meet people's needs. One member of staff explained, "With regards to changing needs, we can communicate this via email, telephone or supervisions (meetings) with our manager." Another member of staff said, "If important new information comes in the care plan is updated and staff that need to know are informed."

People told us they knew how to make a complaint if they needed to. The complaints policy was contained

in the information guide each person had in their home, which was available in different communication formats if needed. One community professional commented, "The service does receive complaints. In all cases, the provider investigates according to their complaints procedures and keeps relevant agencies informed. They take appropriate action where required to ensure similar incidents are prevented in the future."

The manager kept a log of complaints they had received. Where complaints had been recorded in the complaint's log we saw these were investigated and responded to according to the provider's complaints procedure. This meant people knew what to expect when they made a complaint. The manager had discussed concerns with complainants and tried to resolve the person's concerns according to their wishes and to their satisfaction. The manager also logged feedback they received and followed any negative feedback up as an informal complaint. For example, in a recent informal complaint a relative had raised issues about the staff team, the care co-ordinator had visited them in their home to discuss their concerns. Staff changes had been made in response.

Requires Improvement

Is the service well-led?

Our findings

Most of the people we spoke with told us the care they received from Take-a-break was good and that staff were approachable and they could contact the manager when they needed to. One relative said, "Yes, they are pretty good. If they are unavailable they will phone back." One hundred per cent of community professionals who responded to our survey told us the service was well managed, the manager was accessible and responsive.

However, we received a number of comments regarding the communication between the management team, people who used services and staff. Comments we received included; "Communication is really bad. I am having to chase staff for response to my queries as they say they will get back to me but don't", "The communication, it has got to improve", "Communication is not great. They phone at the last minute to say staff were off sick or there was no one to cover."

We asked people how this impacted on their care. One relative told us their relation became frustrated, because when visits were cancelled at short notice they couldn't go out. They said, "It's [Name] who misses out." Another relative told us, "I sometimes get a rota with gaps, that is no good to me. It's a worry because I don't always know who will be coming."

We asked care staff whether there were any improvements the charity could make to assist them with their role. One staff member said, "I thoroughly enjoy working for Take-a-Break. The only improvement I can think to suggest is occasionally their organisational skills can let them down."

We discussed planned improvements with the registered manager and the director of operations during our inspection visit. One of the improvements they had already planned was around staff contract arrangements. The charity had recently conducted a review of their care packages, to ensure they were offering care to people in line with their aims and values. Following this review the management team had reduced the number of people they supported and had also reduced staffing numbers accordingly. People who used the service had been informed about the changes. The staff that remained were being offered permanent contracts with agreed hours' instead of zero hours' contracts. This was due to be implemented following discussions with staff before the end of the year. These changes were to improve people's understanding of how much support the charity could offer. The changes would also help to ensure people received their regularly scheduled visits. The intended improvements were also to ensure a more stable staffing team and to encourage commitment from staff.

The provider had clear aims and values and had communicated them to people who used the service. The provider's aims and objectives were written in the information booklet each person had in their home. Their aim was to provide community based short breaks for children and young people who have a disability or life threatening illness, and adults with learning disabilities. This support enabled people to live their lives to their full potential, gain skills and move towards independence with confidence. One staff member commented, "I think the work we do as a charity is excellent and I am proud to say that I work for Take-a-Break."

The agency was a charitable organisation run by a board of trustees. People who used the service were involved in decision making and were able to be appointed board members. At the time of our inspection visit, two board members had been parents of children who had previously received a service from the charity. This demonstrated people who had used the service were able to take part in decision making about the charity and how the service was delivered in the future.

Care staff at Take-a-break were supported by a management team which consisted of the registered manager, care co-ordinators for each geographical area, and senior support workers. Staff told us they received regular support and advice from their managers via the telephone and face to face meetings. Care staff were able to access support and information from managers at the times they worked as the agency operated an out of office hours' advice and support telephone line, which supported staff in delivering consistent and safe care to people. One member of staff commented, "I feel like I do receive appropriate support from my manager as whenever I have needed support they have got back to me as soon as possible and have taken all suggestions of mine on board. I feel comfortable talking to my managers about any issues I feel that I need to raise."

The manager told us the provider was supportive and listened to their feedback about changes and improvements they wanted to make. They said, "It's a good organisation, I have daily support and contact with directors and senior managers. The provider is flexible and family friendly, they promote a work life balance."

People were asked to give feedback about the quality of care, and how the service was run in a number of ways. People were invited to attend regular review meetings where they were asked for their comments and views. Everyone who used the service and key stakeholders were asked to attend or contribute to the Annual General Meeting of the charity. Surveys were sent to people who used the service, staff members, key stakeholders and relatives each year. The results of surveys were analysed and results were collated. We looked at the comments one person had made in a recent telephone survey and found they were happy with the care they received.

The provider and registered manager used a range of quality checks to make sure the service was meeting people's needs. The manager completed audits in a number of areas including care records, medicines management and staff timekeeping. All checks were documented and showed corrective actions were taken, such as following up missing information in records. Senior staff members and the manager undertook regular 'spot checks' on the performance of staff, to ensure people received good quality care. Spot checks included reviewing the care people received and infection control procedures in people's homes. The director of operations was based at the agency's office and met with the manager monthly to review quality assurance procedures and findings with the manager. Where issues had been identified, action plans were put in place to make improvements.

The manager had sent notifications to us about important events and incidents that occurred. The manager also shared information with local authorities and other regulators when required, and kept us informed of the progress and the outcomes of any investigations. Where investigations had been required, for example in response to accidents, incidents or safeguarding alerts, the manager completed an investigation to learn from incidents. The manager made improvements, to minimise the chance of them happening again.