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care2care

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 25 and 26 April 2016 and was announced with 48 hours' notice.

Care2Care is a Domiciliary Care Agency (DCA) registered to provide personal care in people's own homes. The agency office is based in Didcot. At the time of this inspection 132 people were supported by the agency.

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.

Medicines were not always recorded as administered. Risk assessments were in place which set out how to support people in a way that mitigated the risks they faced. There were enough staff working in the service to support people. Checks were carried out on staff before they began working at the service. Staff had the knowledge and training to recognise and report concerns to keep people safe.

People were supported by staff that had the training and support from their managers to deliver effective care and carry out their roles and responsibilities. The service operated within the Mental Capacity Act 2005 and consent to care was sought by staff before care was undertaken. People's hydration and nutrition was well managed. People were supported to have access to health professionals where needed.

People had caring staff who took the time to get to know those they supported. People were provided with information about their care and privacy and dignity was respected and promoted.

People had been assessed to determine if the service was able to meet their needs. Care plans were accurate, up to date and contained personalised information about people's care and emotional needs and relevant personal history. Regular reviews of people's care needs had taken place. People knew how to complain and complaints were responded to in line with policy.

The registered manager promoted a positive culture that meant people had personalised care from staff that cared for them. The service was well managed with staff commenting how supported they felt and how much they enjoyed their jobs. Records were well kept and up to date which meant care was monitored closely. Quality assurance was monitored and actioned if changes or improvements were needed.

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 mainly safe. Staff had not always recorded when medication had been administered.

Staff had a good understanding of potential abuse and how to report concerns to ensure people were kept safe.

People were appropriately referred to professionals when needed.

People had risk assessments in place to cover individual and environmental risks.

Recruitment systems were robust to ensure staff were safe to work with people in the service.

Is the service effective?

Good

The service was effective. Staff had received appropriate training and received a thorough induction before working with individuals.

Staff were supported both informally and with formal meetings at regular intervals.

People were able to make their own decisions as staff understood and had training on the Mental Capacity Act 2005. The service had engaged with health and social care agencies to meet people's best interests.

Is the service caring?

Good

The service was caring. People spoke highly of the staff.

Staff cared about the people they supported and described the importance of treating people well.

Staff had developed trusting relationships.

People at end of life care received compassionate and supportive care.

Is the service responsive?

Good

The service was responsive. People and their relatives were involved in planning their care.

People's views were reflected in personalised care plans which were reviewed regularly.

Processes were in place to interact with external services. Feedback was sought and concerns and complaints were investigated.

Is the service well-led?

Good

The service was well-led. There was a registered manager in place.

The service worked to ensure it met the values required to ensure people were cared for safely, effectively and respectfully.

Staff were happy in their work, motivated and were confident in how the service was managed.

Quality assurance systems were robust and processes were in place to enable managers to account for actions and performance of staff.

The service works in partnership with organisations to support care provision, service development and joined up care.

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Detailed findings

Background to this inspection

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

This inspection took place on 25 and 26 April 2016 and was announced. We told the registered manager two days before our visit that we would be coming. We did this because we needed to be sure the registered manager would be in the office. This inspection was undertaken by two inspectors.

Before our inspection, we reviewed the information we held about the service. This included details of its registration, previous inspection reports and any statutory notifications submitted by the service. Notifications are information about important events the service is required to send us by law. 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. The PIR was returned as requested.

We contacted professionals and received feedback. This information was reviewed and used to assist with our inspection. We visited the office and spoke with the registered manager, two client managers, two senior carers, two carers, a rota co-ordinator, the trainer and the recruitment manager. As part of this inspection we visited three people in their homes. We also spoke with 10 people. We spent time looking at records, which included 15 people's support plans. We looked at 12 staff recruitment, training and supervision records. We examined information relating to the management of the service, such as quality assurance audits and reports. We also looked at the safeguarding adults and whistleblowing policies and procedures and the complaints policy.

Good

Is the service safe?

Our findings

The service did not always have clear and accurate medicines records in place. One person, who received three daily visits for support with antiepileptic medicines, told us that the carer had not signed the medicine administration records (MAR) chart at lunchtime on two days during the previous week. However, the medicines had actually been given. When we checked the MAR chart we saw that it had not been completed for these times although administration had been recorded in the person's daily notes of care. We discussed this with registered manager who said they would investigate why the MAR chart had not been completed as it should have been.

Staff were trained by the provider's in-house trainer to support the administration of medication. A carer told us they were "medication trained". The care plan indicated whether carers were to 'assist, prompt or administer' medicines. Some people were prompted or reminded to take their medicines. This was recorded in the daily notes of care. Others were assisted to take their medicines by the carer and they would sign the medication administration records (MAR) chart. For other people, carers actually administered medicines. A relative said "They help with medication and it's been going well". A person whose medicines were administered by carers told us that staff observed that the medicine had been taken before they completed the MAR chart.

We reviewed the medication policy. Senior staff told us that carers did not administer controlled drugs. These were administered by a professional such as the district nurse. If a person refused medication, carers would notify management and the GP would be contacted for information and advice. A person told us that they managed their own medicines "I only take paracetamol and I do that myself." When, with their permission, we reviewed the person's folder we saw that carers assisted with the application of topical creams and recorded this. They said carers were "Alright" in applying topical creams.

People told us they felt safe with the service provided. One person told us "I couldn't do without them." Another person told us "I can't feel unsafe. They do their best." A relative we spoke with said, "Yes, I do think [relative] is safe with them".

People felt there were enough staff. One person said 'I've had no missed visits and yes they do come on time. They'd ring if they were to be late". Another person said carers "Always come" for calls. They told us "They won't leave me." However, a couple of people we contacted said calls weren't always on time. They said "They're not always on time but this is not their fault as the traffic is really bad, they would usually ring me if they were going to be late. Never had a missed visit". Another person said "There is a slight issue, sometimes they are late".

We spoke with the rota co-ordinator who explained that delays did sometimes occur but people were contacted as the service used an electronic call monitoring (ECM) system which enabled office staff to see whether a carer had logged in and out for their scheduled visit. Senior staff told us that the service was found by the local authority to be 94% compliant. A carer told us that ECM "helps a lot". Carers we spoke with told us there were enough staff to meet people's needs. One staff member told us the ECM system

helped the office to notify people and said "They see if I'm running late."

People were protected by the registered manager being familiar with the processes to follow if abuse was suspected. Staff we spoke with told us they had received safeguarding training and updates. A care co-ordinator told us they dealt with safeguarding matters. We saw evidence of discussion regarding a safeguarding that had been reported and saw the outcome from the local authority. We sat in on a safeguarding session for new staff. A discussion was held on a recent documentary about a domiciliary care agency and recent legislation regarding Duty of Care. The training also addressed how people's human rights could be violated with the wrong care and the right to a private life. For example, a situation was discussed of how carers may handle situations where someone refused care and how this could mean carers were neglectful if they did not follow the right procedures.

Staff files contained a completed application form detailing employment history, offer letter, proof of identify, two references and interview notes. References had been followed up. All of the files seen contained evidence of a Disclosure and Barring Service (DBS) clearance prior to starting employment. A DBS check provides information about any criminal convictions a person may have. This helped to ensure the service had a good recruitment process; people employed were of good character and had been assessed as suitable to work in the service.

Regular 'spot checks' on staff had taken place. These are unannounced visits by senior care staff to assess how a carer is carrying out their work in people's homes. A carer confirmed that their medicine practice had been assessed during a spot check. We saw that spot check records were reviewed before supervision sessions to see if any issues needed addressing.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. These included assessments for epilepsy, risk of falls, allergies, medication and finance. For example, we saw a risk assessment in regards to a person's stoma and the risk of infection. It detailed the signs to note, such as broken skin or high temperature and action to follow which was contacting the GP or district nurse. All risk assessments had been reviewed annually.

People's homes had been risk assessed to ensure people's homes were as safe as possible. This included checking smoke alarms were working, carpet and rugs posed no risks and stairs were safe. Staff had also undergone lone worker risk assessments to consider their safety in their roles. For example, there were prompts to ensure carers carried torches and had a charged mobile phone.

We saw that people had contact telephone numbers for the office and for the on call staff member. People had emergency call bells such as pendant or wrist worn alarms and mobile 'phones to enhance safety.

People were protected in the event of an accident or incident. For example, we saw a carer who found a person had a blocked catheter so had called 111 for advice and called the district nurse.

Staff had undergone infection control training and were issued with the correct and appropriate amounts of personal protective equipment, such as aprons and gloves.

Good

Is the service effective?

Our findings

People felt staff were well trained in their role as carers. A person told us that they were well prepared for their roles saying, "They know everything. They have to jot it down every day." Another person told us that "some" carers were well prepared and that "I'm prepared to educate them, especially the newer ones."

Staff received an induction before they started work with people in the service. We spoke with a staff member who said, "I went through all the checks and references were chased up, and had a DBS check" they went on to say "It was a comprehensive process". One person was receiving support from a new member of staff. They confirmed that the person was being supervised by a regular member of staff during their visits. They added "[Carer] is getting to know my likes and dislikes."

People were supported by staff that had good knowledge and training in care. The service had a full time training officer who was facilitating mandatory training at an induction course for new staff at the time of our inspection. All new staff spent a week with the trainer before undertaking any home visits. We observed that the service had a training room that contained equipment such as a profiling bed, a hoist and a standing frame. This meant that new carers and those undertaking update training could put theory into practice by using the equipment. Staff we spoke with had received mandatory training and updates. A carer told us they had completed training in topics including safeguarding adults, first aid, infection control and moving and handling. Two staff we spoke with were in the process of completing national qualifications in health and social care. They told us they were also due to have "Training on assessments". A carer told us that when they started in post, they had a period of shadowing an experienced carer before working independently.

We were told that staff undertook risk assessments in their own home as part of their training. This helped them to consider different risks that may be present and to give them a safe opportunity to discuss before undertaking risks assessments for people in the service.

There were senior staff who were office based but who also carried out client focused activities including initial assessments, making care visits, doing spot checks of care staff and conducting quality monitoring visits. Office based senior staff included two care co-ordinators, the manager. An area manager worked 'in the field' as did senior carers. Staff who undertook assessments for new people into the service had a two day training which included, relevant legislation, undertaking risk assessments, completing care plans and use of body maps. They also completed a mock assessment on someone they knew well. This gave a good example to the trainer of the staff's understanding.

Staff had regular supervision and an annual appraisal. We saw a monthly supervision matrix showing when the last supervision had taken place and when the next one was due. These were held every three months in line with the supervision policy. Staff also had an annual appraisal where their overall role was reviewed and any development needs were discussed. Staff told us they felt supported by their manager. We had comments such as, "

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible'.

People can only be deprived of their liberty so that they can receive care and treatment when this is in the best interests and legal authorised under the MCA. The application procedures f this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager and other staff had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had completed training on the MCA and DoLS during their initial week's induction course. This meant they were able to ensure people had choices and their rights weren't withheld. Staff we spoke with showed a good understanding of consent issues in practice. Senior staff told us that, as part of the initial assessment process, people were asked about their preferences such as gender of carers providing personal care. A carer told us that with consent it was important to offer choices to the person.

A senior staff member told us they had been involved in 'best interests' meetings. For example, a decision was being discussed about a person in hospital returning home. The staff member knew the person very well and was able to provide information at the meeting to ensure the relevant information was considered for the best outcome. A decision was made for the person to return home and they were doing very well following this.

A care co-ordinator we spoke with told us they took a leading role in "care liaison" with various agencies and professionals. A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. These included the GP and district nurse. A person might require a specific assessment, for instance by a speech and language therapist (SALT) for swallowing difficulties (dysphagia). During a home visit, we met a physiotherapist who was assessing a person's mobility and equipment needs. Another person we visited told us an occupational therapist had visited regarding possible adaptation to their bathroom which they were unable to access.

Staff we spoke with were aware of the importance of encouraging people to have a good intake of fluids and food. We saw in records about providing a hot meal of choice, or what assistance was needed to help the person prepare their lunch and drinks. People we spoke with felt they were supported well with regards to this.

Good

Is the service caring?

Our findings

People and relatives we spoke told us that staff treated them well. A person told us they valued their support. "You couldn't wish for better." Another person said, "The staff are good, we've had two lovely young ladies today and they were excellent". Someone else said the carers "Work very hard" and that they were "Pleased" with the care provided. They mentioned an occasion when carers had been called back to the house after the last visit of the day because further personal care was needed. "I couldn't fault them in any respect." A relative told us, "Most of the time it's very good."

We were told that most clients had regular carers they knew. A relative we spoke with said "I have been here on occasions when the staff were in the house and I saw two or three regular faces. It's nice when they get regular people so they can build relationships. They are lovely; they chat to my [relative] and hang their washing out and help".

Staff we spoke with thought the service was caring and carers referred to positive feedback they received from people. A carer told us "I enjoy the job." Staff spoke fondly of the people they cared for and had a good understanding of the needs of individual people. They said they worked with people over time and this enabled them to build good and trusting relationships with people. A person told us, "They're caring and polite; we have a bit of laugh and chat".

Care plans also included information about people's likes and dislikes which again helped staff to understand people. Staff understood the need to provide care in a personalised manner. One staff member told us, "I treat them [people that used the service] as valued adults, not as a condition [referring to any medical diagnosis people may have had]."

People told us they were treated with dignity and respect and had their privacy respected. Staff we spoke with told us they respected people's privacy and dignity, for example by knocking on the door before entering a person's home. Another staff member said "I would cover personal areas of body. If person was on a toilet I would offer the choice to leave them for a while". We had comments from people when asked if staff respected their dignity and privacy such as "Oh yes, they respect this" and They will draw the blinds before they wash me in bed" and "Yes, they are all very aware of that". People were encouraged with maintaining independence as much as possible. For example, choice of washing their own face.

People had been given information about the service. People were provided with a copy of the service user guide with contact details. A person said," I have the number for the office, it's in my book here, I can call them if I need to".

When people were receiving end of life care more experienced carers were allocated. The service said it did all it could to ensure that the person could stay at home if that is what they wanted. Staff said they were supported to attend funerals of those they had cared for if they wanted to go.

Good

Is the service responsive?

Our findings

People and relatives told us they were happy with the support provided. They also felt the service responded to requests. For example, the timing of visits and the gender of carers who provided personal care. A person told us "I won't have men" and they confirmed they had female carers. We saw examples of the service varying times of visits. A carer told us they supported two clients whose visit times had been adjusted.

Care plans were developed from the initial assessment with the person. We saw an assessment on a person's records. This showed the person was present and had signed it. It contained full information on the person's needs including important health issues, such as diabetes, pressure sores, continence and falls.

Care plans contained 'My care plan' which was an overview of the directions for morning, lunchtime, tea and evening visits. A person told us that carers "Write down everything they do".
A senior staff member told us their role included "Keeping care plans updated". All care plans had annual updates and changes had been made when needed. Staff told us that they thought the service was responsive and that care plans reflected people's changing needs.

Care plans we reviewed had a clear structure including sections on a description of client needs, a risk assessment, care plan, client reviews and evaluation of care needs. Any risks identified on the initial risk assessment were assessed separately on an individual risk assessment form. Care plans were reviewed regularly and people and relatives had the opportunity to be involved in six monthly reviews. We saw a comment on a review completed January 2016 which said 'Very happy with care. All carers are polite'.

People knew how to complain if they needed to. One person visited said that they would make a complaint to the manager if they felt they had to but added "I've no complaints at all so haven't had to." Another person said "I never had the reason to complain, I'd go straight to [staff name], she's very nice and helpful, and you can speak to her. I have no complaints. I have information in my file how to contact the office if needed". We saw a complaints policy which stated that complaints would be acknowledged in three working days and an outcome would be reached within 29 days. For example, we saw a complaint about a morning call that was too late. We saw this had been adjusted and it was recorded the person was happy with new time. This had been done within timescales.

We received feedback from a professional who stated two of their clients were supported by the service. They said "In both cases there have been sudden changes to the client's health which have necessitated significant changes to the packages of care at short notice. I found Care2Care to be responsive to the needs of my clients and have accommodated changes where possible at very short notice. I have received positive feedback from both clients regarding the care staff and I find that the team are quick to communicate any issues of relevance back to me. Overall I have been incredibly impressed with the level of service they provide".

Good

Is the service well-led?

Our findings

People felt the service was well-led. Comments included, "They are all very good, yes, I've got everything I need; I'm happy overall" and "I'd definitely recommend them".

The service had a company vision of being a family run business who were committed to the providing the best standards of care through training, monitoring and selecting the right individuals who we can trust to support and care for our clients. Their values were stated as dignity and respect, openness and commitment.

There was a registered manager in place and a clear management structure. The registered manager and other senior staff had a clear area of responsibility and staff knew who their line manager was. Staff were aware of their roles and responsibilities. There was evidence of an open and inclusive culture that reflected the values of the service.

All of the staff spoken with said their managers' were approachable and supportive. Staff members told us they felt the service was well managed and organised. Comments heard included, "Job is incredible and I'm comfortable here", "Can tell [management] anything", "A senior staff member is always available 'on call' for people and staff until 2200hrs and during the weekend". One staff member we spoke with felt very supported and had received "Unbelievable support" from their supervisor when they had been unwell.

Staff told us communication was good. Staff said team meetings took place and there were opportunities to discuss how things could be improved, for example, the on call system. Birthdays were celebrated. We saw meeting notes where people had discussed training and supervisions. There was a discussion around refused calls and how to manage these. Staff were praised for their hard work and commitment.

The service had a whistleblowing procedure. A whistle-blower is anyone who has and reports concerns of wrongdoing occurring in an organisation. This is usually reported to a manager or someone they trust or it can be to an outside agency such as the local authority safeguarding team or the Care Quality Commission. A staff member said "I would speak to my manager".

The registered manager analysed information about the quality and safety of the service Comprehensive quality assurance monitoring was in place. Audits were undertaken as part of the quality assurance process to monitor the quality of service people received. Any gaps or shortfalls identified during these audits were addressed by improvement plans.

The service had developed a 'client request sheet'. Any one calling in to request a change to their visits are recorded and handed to the relevant department for action. The form then has to be signed off and checked by a Manager. This had improved the system and since it had been in use fewer complaints were received. The service had analysed the type of requests asked for to enable them to assess any changes to the service that may be needed.

The service worked well with other agencies and services. One of the client managers described the close working relationship with all professionals involved in people's care including the local authority, key workers, hospital social workers, GPs, housing associations, older person support and Community Voice. They described how they would contact agencies to get appropriate information. They also worked closely with 'Hospitals at Home'. The care co-ordinator said "We work together all the time".

All policies and procedures were kept under review to ensure they remained up to date and appropriate. A contingency plan was in place in case the service was affected by situation such as severe weather or fire in the office premises. This included identifying the most vulnerable people.