Care Outlook Ltd

Care Outlook (Oxford)

Inspection report

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Tel: 01865771348

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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

We inspected this service on 10 May 2017. Care Outlook (Oxford) is a domiciliary care agency that provides care to people in their homes in and around Oxford. At the time of this inspection, the agency was supporting 40 people.

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 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 registered manager worked closely with the director of operations.

At the last inspection on 11 April 2016, we asked the provider to take action to make improvements and make sure people's capacity assessments were completed in line with the Mental Capacity Act 2015 (MCA) and that staff had a good understanding of the MCA. At this inspection on 10 May 2017 we found the actions had been completed.

The registered manager and staff had a good understanding of the MCA. Where people were thought to lack capacity to make certain decisions, assessments in relation to their capacity had been completed in line with the principles of the MCA.

People who were supported by the service felt safe. Staff had a clear understanding on how to safeguard people and protect their health and well-being. People received their medicines as prescribed.

There were enough suitably qualified and experienced staff to meet people's needs. The service had robust recruitment procedures and conducted background checks to ensure staff were suitable for their roles.

People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Where risks to people had been identified, risk assessments were in place and action had been taken to manage the risks. Staff were aware of people's needs and followed guidance to keep them safe.

Staff received adequate training and support to carry out their roles effectively. People felt supported by competent staff that benefitted from regular supervision (one to one meetings with their line manager) to help them meet the needs of the people they cared for.

People's nutritional needs were met. People were given choices and were supported to have their meals when they needed them. Staff treated people with kindness, compassion and respect and promoted people's independence and right to privacy. People received care that was personalised to meet their needs.

People were supported to maintain their health and were referred for specialist advice as required. Staff knew how to support people during end of life care.

Staff knew the people they cared for and what was important to them. Staff supported and encouraged people to engage with a variety of social activities of their choice in the community.

The service looked for ways to continually improve the quality of the service. Feedback was sought from people and their relatives and used to improve the care. People knew how to make a complaint and complaints were managed in accordance with the provider's complaints policy.

Leadership within the service was open and transparent. People, their relatives and staff were complimentary about the management team and how the service was run.

The registered manager informed us of all notifiable incidents. The registered manager had a clear plan to develop and further improve the service. Staff spoke positively about the management support and leadership they received from the management team.

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.

Risks to people were managed and assessments were in place to manage the risks and keep people safe.

There were sufficient numbers of suitably qualified staff to meet people's needs.

People were protected from the risk of abuse as staff had a good understanding of safeguarding procedures.

Medicines were administered safely.

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills to support people effectively.

People were supported to have their nutritional needs met.

Staff had good knowledge of the Mental Capacity Act 2005 and applied its principles in their day to day work.

People were supported to access healthcare support when needed.

Is the service caring?

Good

The service was caring.

People were treated as individuals and were involved in their care.

People were supported by caring staff who treated them with dignity and respect.

Staff knew how to maintain confidentiality.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were current and reflected their needs.

People's views were sought and acted upon.

People knew how to make a complaint and were confident complaints would be dealt with effectively.

Is the service well-led?

Good

The service was well led.

People and staff told us the management team was open and approachable.

The leadership created a culture of openness that made staff and people feel included and well supported.

There were systems in place to monitor the quality and safety of the service.

Care Outlook (Oxford)

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 was carried out by an inspector and an Expert by Experience. An Expert by Experience experts by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection took place on 10 May 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office.

Before the inspection we reviewed the information we held about the service and the service provider. The registered 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 looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We obtained feedback from commissioners of the service.

We spoke with 11 people and four relatives. We looked at four people's care records including medicine administration records (MAR). We spoke with the registered manager, one office coordinator, one monitoring officer and three support staff. We reviewed a range of records relating to the management of the home. These included five staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. In addition we reviewed feedback from people who had used the service and their relatives.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe receiving care and support from Care Outlook. They commented; "I do feel safe with them" and "I certainly am safe with them". People's relatives told us, "We feel [person] is very safe with them" and "Oh yes we feel safe knowing they are looking after [person], absolutely".

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff had completed safeguarding training and understood their responsibilities to identify and report any concerns relating to abuse of vulnerable adults. One member of staff told us, "We report any abuse concerns to manager, safeguarding or CQC".

People's care plans included risk assessments and where risks were identified there were management plans in place to manage the risks. Risk assessments included risks associated with: mobility, medicines, nutrition and environment. For example, one person's support plan identified they were at risk of falling due to poor mobility. They had a risk management plan which guided staff on how to encourage the person to use mobility equipment and ensure they wore their alarm pendant always.

People received their medicines as prescribed. There were systems in place to manage medicines safely. The provider had a medicines policy and procedures in place which took account of the local shared care protocols. Shared care protocols are a shared agreement between organisations which ensures safe management of a prescribed medicine.

Staff had completed medicines training and where staff were required to have training specific to a person's prescribed medicine, this was completed by an approved health professional before staff supported the person. For example, when supporting a person with blood thinning medicine.

Records relating to the administration of medicine were accurately completed. Medicine administration records (MAR) detailed the number of medicine administered from a monitored dosage system. Where medicines were not dispensed in a monitored dosage system MAR had details of the medicine which included; dose, strength, method of administration and frequency.

People were supported by sufficient numbers of staff. Records showed the number of staff required for supporting people was increased or decreased depending on people's needs. Staff told us, "We have enough staff. We hardly have any missed calls". People told us their received their calls as agreed. People told us, "They [staff] turn up on time and if they are running late someone rings from the office" and "They [staff] are on time unless they get caught in the traffic". Records showed there were no unexplained missed calls recorded. The provider had an effective system to monitor calls.

The provider followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with

vulnerable people.

Good

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and to report our findings. The 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.

When we last inspected Care Outlook on 11 April 2016, we found the registered manager and senior staff were not clear on their responsibilities to ensure the service completed their own mental capacity assessments if it was thought a person may lack the capacity to make certain decisions. Staff did not always have knowledge and awareness of the MCA as they had not received any training. These concerns were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection on 10 May 2017 we found improvements had been made. The registered manager and staff followed the MCA code of practice and made sure that the rights of people who may lack mental capacity to take particular decisions were protected. Where people were thought to lack the capacity to consent or make some decisions, staff had followed good practice guidance by carrying out capacity assessments. Where people did not have capacity to make certain decisions, there was evidence of decisions being made on their behalf by those that were legally authorised to do so and were in a person's best interests. For example, where people refused personal care and had no insight on why they needed to be assisted with personal hygiene.

People were always asked to give their consent to their treatment and support. Staff we spoke with told us they would explain support to be given and seek the person's consent. We saw in support files that people, gave consent for care and support they received and family members and advocates were consulted to ensure decisions were made in people's best interest.

Staff had received training in the MCA understood their responsibilities. Staff told us, "We assume capacity in the first instance unless proven otherwise", "We monitor our clients and record changes. When we see changes that affect their well-being, we perform capacity assessments" and "We support clients in their best interest if they lack capacity".

People told us they received care from staff who had the skills and knowledge needed to carry out their roles. People's comments included; "They are all really good and know what they are doing" and "They all seem to know what they are doing and very professional". One person's relative said, "They [staff] are so well organised and know what to do".

Staff told us they felt supported and received regular supervisions (a one to one meeting with their line manager) and an annual appraisal. Staff told us they found one to one time with their manager useful. One member of staff said, "We have supervisions every three months and we discuss concerns and how to

improve". Staff practice was monitored using regular spot checks to ensure they were competent in the skills and knowledge required for their role. The registered manager also facilitated staff discussions following any poor practice, for example, when medicine errors occurred.

New staff completed an induction period, this included three days of training and shadowing more experienced staff before working alone. The induction training was linked to The Care Certificate standards. The Care Certificate is a set of standards to ensure all staff have the same induction and learn the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. One new member of staff told us, "Induction included training days, practicals and shadowing other staff afterwards. I had a field observation before being signed off".

Where people required support to meet their dietary needs this was detailed in their support plans. People told us they were supported to have meals of their choice. Their comments included; "They do my breakfast, just whatever I want, they always ask me" and "They do my meals, I have meals delivered and the girls read out from the list of what's in the freezer, I choose and they make me a drink". One person's relative told us, "They [staff] do [person's] meals, just what we leave out for them, that's all okay".

People were supported to maintain good health and access health professionals when needed. People's support plans showed people had been referred to GP, district nurses and out of hour's services when needed. People told us they were supported to access on going health care. They said, "I had a fall the other day and [staff] stayed with me the whole time the ambulance was here. Even though [staff] had another call to go to, they stayed until everything was okay".

Good

Is the service caring?

Our findings

People told us Care Outlook staff were caring. They said, "They are lovely girls I have at the moment. They are nice to me and very polite", "We have smiles on faces from the time they come in, which is how I like it" and "The girls are very polite, most pleasant". People's relatives told us staff were caring. They said, "They are very pleasant and thorough" and "Oh they are wonderful, truly excellent. I couldn't find anything to complain about if I tried".

Staff told us they were caring and treated people with kindness. Staff gave examples of when they showed kindness by being patient and taking time to talk with people about things that mattered to them. Staff understood the importance of building relationships but were aware of their responsibility to remain professional. One member of staff said, "I have good relationships with people but keep it professional". People told us staff knew them well. One person said, "They always ask what I want and we have a nice talk".

People were treated with dignity and respect by staff. Staff ensured people received their care in private and respected their dignity. Staff told us how they treated people with dignity and respect. Comments included; "We explain things every time, close doors and curtains before supporting with personal care", "We cover clients during personal care" and "Everyone has their own choices and preferences and we respect that". Staff spoke about people in a caring and respectful way. Care records reflected how staff should support people in a dignified way and respect their privacy. Support plans were written in a respectful manner.

People told us they were treated with dignity and respect. They said, "They [staff] treat me with respect" and "I have certain things that I want done in a certain way and the girls respect that". One person's relative told us, "[Person] asked for lady carers only and they have obliged with that. That's respectful".

People told us staff supported them to be independent. People said, "I do my own meals but they make me a coffee if I want one. It's the few things I can still do for myself and they support me" and "They [staff] used to do my meals but now with their help I've progressed to being able to do my meals myself again". Staff understood the importance of promoting independence and involving people in daily care. They explained how they allowed enough time and did not rush people. This enabled people to still do as much as they could for themselves with little support. One member of staff commented; "We let people do what they still can. At times they just need a nudge".

Staff told us they understood and respected confidentiality. Comments included; "We report things on a need to know basis", "We don't discuss clients with people outside work" and "We keep our documents securely". Records were kept securely and only accessible to staff.

Staff told us they had supported people through end of life following training. The registered manager told us training in end of life had been provided to ensure staff knew how to support people.

Good

Is the service responsive?

Our findings

People's care and support was planned with them. The registered manager assessed people's needs prior to accessing the service to ensure their needs could be met. They met with people, their relatives and healthcare professionals to complete the assessments. These assessments were used to create a person centred plan of care which included people's preferences, choices, needs and interests. People told us they were involved during assessments. People said, "I have only just started with them but [staff] came out and did a thorough care plan, wrote everything I wanted. [Staff] asked me about my life and background and did a little piece on that. Went right round the house checking on everything and I signed all the forms, so we know where we stand which is excellent" and "They came to the hospital in the first instance and did a thorough care plan and they have been out several times to review it".

At the front of people's files there was a profile that highlighted what was important to the person. For example, one person's profile stated 'I used to work in the army and I like plane. I like routine'. This enabled staff to know a little about the person, provide personalised care and promote the development of relationships. One member of staff told us, "We use the profile information as start up for conversations".

People's support plans contained details of when support calls were required and the support people required at each visit to ensure their assessed needs were met. For example, one person's care plan detailed when they preferred to have a shower or bath. People told us they were involved in the planning of their care and support. Comments included; "I did my care plan, I've got it here in the folder" and "We did all the paperwork together and agreed everything, it's all in the house along with the sheets they fill in every day".

Support plans were reviewed regularly to reflect people's changing needs. Where a person's needs had changed, the support plan had been updated to reflect these changes. For example, a person's calls were increased when they came out of hospital. The person's care plan was reviewed and reflected the changes. People told us they were involved in the review of plan of care. People said, "They [staff] come quite regular to review it and see if everything is alright" and "[Staff] comes out and we check everything, she has been out a few times". One person's relative echoed, "[Staff] comes from the office to check on things and ask us questions".

People were encouraged and supported to maintain links with the community to ensure they were not socially isolated. For example, attending a day centre or a befriending service. The service planned people's care visit times flexible enough to accommodate their interests as well as any other social commitments. People were matched with staff who had the same interests and they could request certain staff members. For example, one person requested an 'older and mature' member of staff and this was respected.

The provider had systems in place to share information between different care staff visiting. A copy of the care file was kept in people's homes for care staff visiting to look at and a copy was also kept securely in the registered provider's office. Staff wrote daily notes kept in a folder in people's homes. This recorded details of the care and support provided at each visit, including the time and length of calls, the support provided and any issues or concerns identified. This helped to ensure that information was handed over to the next

member of care staff visiting that person. Office staff also completed 'journals' to log in any communication and updates from people, healthcare professionals as well as people's relatives.

People's views and feedback was sought through service user reviews, telephone monitoring and satisfaction surveys. People and their relatives told us they had participated in surveys. People's comments included; "I have had a survey a little while ago", "Someone comes from the office, I have had a questionnaire" and "[Staff] comes from the office to see me sometimes and ask me questions about things and about the carers".

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. This was given to people and was also available on request. People told us, "I have never had to complain, Lord no", "I have never had a complaint, anything has been super small niggles that's easily put right" and "I have only had some small problems and I said to [staff] and it was sorted out, not complaints really". We looked at the complaints records and saw there had only been one complaint which had been dealt with in line with the provider's policy. Records showed the complaint raised had been responded to sympathetically, followed up to ensure actions completed and any lessons learnt recorded. People spoke about an open culture and felt that the service was responsive to any concerns raised. The service had received many compliments and positive feedback about the staff and the care people had received.

Good

Is the service well-led?

Our findings

Care Outlook was led by a registered manager who was supported by a director of operations. The registered manager had been in post for four and a half years. They demonstrated strong leadership skills and had a clear vision to develop and improve the quality of the service.

The service had a positive culture that was honest, open and inclusive. During our visit, management and staff gave us unlimited access to records and documents. They were keen to demonstrate their caring practices and relationships with people. Staff told us they felt the service was transparent and honest. Staff said, "Strongly open and transparent organisation. We do not cover up any wrong doing but deal with it there and then", "If we report things to the office, they act and deal with them immediately and "We encourage clients to tell us when we get things wrong so we can put them right". The registered manager told us, "We put our hands up if we get things wrong and learn from that".

Care Outlook valued staff contribution at all levels. Staff were encouraged to make suggestions and be confident these were taken on board. Staff felt listened to. One member of staff told us, "Manager asks for our opinions and takes them into account" and "Our contributions are taken on board and that makes us part of a team".

The registered manager told us one of their biggest challenges had been staff recruitment. The registered manager told us they had pulled out of the 'help to live at home' project due to staff recruitment problems. The contract would require the service to accept all referrals. The registered manager said, "We handed back clients as we were struggling". The registered manager had introduced recruitment days in shopping centres and been involved in job fairs. They had managed to recruit enough staff to meet people's needs. The provider increased staff rates for evenings and weekends to aid staff retention. The provider also introduced staff incentives, for example, 'introduce a friend' scheme to encourage recruitment.

The management team covered care visits when necessary and saw this as an important part of their leadership role in supporting staff and leading by example. The registered manager said, "Staff like seeing me get my hands dirty and it gives them confidence in me as a manager. When I work with clients I can see how care is given". One member of the management team told us, "We do care calls and it's a good way to review people's feedback".

Staff were positive about the management of the service. Comments included; "Manager is very good and supportive, always available for support", "Manager is principled. Any problem, she will always listen" and "Manager goes above and beyond to make us comfortable. We appreciate [manager]". Staff told us the registered manager and management team had an open door policy and were always available when needed.

People and their relatives knew the registered manager and told us the service was well managed and they had good communication with office staff. People's comments included; "It's first class, I can't fault it. You can ring the office easy, they always answer. It is an excellent service", "It is a very well organised service. I

know, I had care when I came out of hospital with another agency and it was dreadful, just dreadful, so I know how good this is" and "It is a superb service, I can't fault it all. If you ring them up they are really helpful". One person's relative complimented, "It has been a brilliant service and I think I struck lucky with them. I talk to the office quite a lot or they contact me if something isn't right".

Staff told us there were good communication systems in place. Staff received weekly newsletters, phone messaging to share information effectively. Staff also used daily logs to update each other on any changes. One member of staff said, "We record on daily logs and share information that way".

The provider had effective quality assurance systems in place to assess and monitor the quality of service provision. For example, quality audits included medicine safety, safeguarding and care plans. Quality assurance systems were operated effectively and used to drive improvement in the service. For example, one medication audit identified gaps on a MAR chart. The member of staff involved was observed giving support with medicines to ensure they recorded on MAR chart following support with medicines. This was emphasised to staff through weekly news letters.

The provider had a clear procedure for recording accidents and incidents. Accidents or incidents relating to people were documented, thoroughly investigated and actions were followed through to reduce the risk of further incidents occurring. For example, one person received two doses of blood thinning medicine in one day. Staff sought medical advice and the person's blood levels were checked. The registered manager investigated this and learning was shared with all staff. The registered manager audited and analysed accidents and incidents to look for patterns and trends to make improvements for people who used the service. Staff knew how to report accidents and incidents.

The provider had a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy. One member of staff said, "I can whistle blow any wrong doing that puts people in danger. We have a procedure to follow".

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.