Creative Living Care Services

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 14 November 2016 and was announced in accordance with our current methodology for domiciliary care inspections. The service was last inspected on 29 September 2014 when it was fully compliant with the regulations.

The service is required to have a registered manager and there were two registered managers 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. One of the registered managers was also the provider and nominated individual for the service. They had stepped down from the registered manager role and told us they would put in an application to cancel this officially.

Creative Living Care Services is a domiciliary care agency that provides personal care and support to people in their own homes. They support adults with a variety of disabilities and health conditions. At the time of our inspection the service was providing a service to 57 people, 37 of these were receiving support with their personal care needs. The Care Quality Commission has responsibility for regulating personal care and this was the area of the service we looked at. The number of hours of support people received varied from two hours a week up to 24 hours per day.

Risk assessments were generic in nature and not accurately reflect people's individual needs. For example, one person had been identified as being at risk of falls but there was no assessment in place to guide staff on how they could minimise this risk.

People told us they felt safe while receiving care and support and reported that staff always respected their privacy and dignity. Comments included; "They're more like friends coming in to help", "I feel like I've known them for ages" and "They're a pleasure to have come in."

Visit schedules did not always include travel time between consecutive visits. This meant carers had to cut visits short in order to stay on schedule. Staff felt the lack of travel time impacted on their opportunity to spend time talking with people. No-one reported any missed visits.

The service operated safe recruitment practices and all staff had received safeguarding training. The service safeguarding policy contained details of contact numbers for staff to use if they needed to raise a safeguarding concern. Policies and procedures were provided to staff in a staff handbook.

All staff received induction training when they joined the service. Training was regularly refreshed and appropriate additional training was provided to help ensure staff remained sufficiently skilled to meet people's individual needs. Staff supervisions and staff meetings were not taking place as regularly as planned but staff told us they were well supported. The deputy manager carried out 'spot checks' to observe

staff working practices. The service operated an on call manager system to provide staff with any necessary guidance outside of office hours. Staff told us, "There's always someone at the end of the phone."

Care plans lacked detail and did not reflect people's individual needs. The care plans outlined what basic care and support people required but there was a lack of information regarding people's preferences in how care was delivered. We have made a recommendation about developing personalised care plans.

Systems for gathering the views of people, their relatives and staff were not robust. Staff meetings were held infrequently. Surveys to gather people's views had not been circulated since mid 2015. There had been no formal analysis of the results.

The registered manager valued the staff team and was keen to develop incentives to help retain staff. Staff told us they were well supported and encouraged to develop skills and work towards additional qualifications.

The registered manager had a clear vision for the development of the service and was keen to maintain a personal approach to supporting people. Members of the management team attended regular forums held by the local authority.

We identified breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not entirely safe. Processes for assessing and documenting identified risk were not robust.

Travel time was not routinely built into staff rotas. This meant staff had to cut visits short in order to stay on schedule.

Recruitment procedures were safe and staff understood procedures for the reporting of suspected abuse.

Is the service effective?

Good

The service was effective. There were appropriate procedures in place for the induction of new members of staff.

People's choices were respected.

When appropriate food and fluid intake was monitored.

Is the service caring?

Good

The service was caring. Staff demonstrated a genuine concern for people's well-being.

People's preferences and likes and dislikes were respected.

Information was provided in a meaningful and accessible way.

Is the service responsive?

Good

The service was responsive. Care plans were regularly reviewed.

Some care plans lacked detail regarding people's routines and the tasks staff were expected to complete.

Daily records were completed and information about people's changing needs was highlighted to staff.

Is the service well-led?

Requires Improvement

The service was not entirely well-led. Systems to gather views of people and staff were not robust.

There were clear lines of accountability and responsibility. The registered manager valued the staff team.

There were quality assurance processes in place to help the registered manager monitor the service provided.

Creative Living Care Services

Detailed findings

Background to this inspection

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

The inspection took place on 14 November 2016 and was announced. This meant we gave notice of our intended visit to ensure someone would be available in the office to meet us. The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed the Provider Information Return (PIR) and previous inspection reports. The PIR 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 also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we met three people who used the service and two relatives. We spoke with the provider, the registered manager, the deputy manager and a member of staff. We also inspected a range of records. These included three care plans, three staff files, training records, staff duty rotas, meeting minutes and the services policies and procedures. Following the inspection visit we spoke with four members of staff, three people who used the service and two relatives. We also contacted two external healthcare professionals to hear their views of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe when being supported by staff from Creative Living Care Services. Comments included; "They are all decent girls, I have no problems at all."

Staff had received training in safeguarding adults and children. Safeguarding and whistleblowing policies were in place which included details of how to recognise the various types of abuse. Staff knew how to report any concerns or incidents of abuse or poor practice both to the Creative Living Care Services management team and outside the organisation if necessary. They told us they would not hesitate to report any concerns. One commented; "It would anger me, I don't understand how people can do things like that." Where concerns were identified the registered manager took the appropriate action, reporting these to the local safeguarding team and ensuring measures were taken to protect people from risk. Information about local safeguarding processes was given to staff in a staff handbook when they started working for the service.

Risk assessment documentation was included within people's care plans. These assessments had been completed as part of the care planning process and identified risks to both people and staff during care visits. For risks in relation to the environment, assessments were in place with information regarding any potential hazards staff might encounter. For example, poor street lighting, parking difficulties, pets and trip hazards. There were risk assessments in place for moving and handling and medicines. However, these were generic and were laid out largely as a 'tick box' format. The information was not specifically written to reflect people's individual needs and did not provide staff with any depth of information. For example, one person required support with equipment to move safely. There was a risk assessment in place for each transfer, eg bed to commode. In total there were four of these assessments. Apart from the brief description of the transfer the risk assessments were exactly the same. There was no detail regarding the best way to support the person such as when they might need further reassurances. The only detail documented in each instance was; "Staff to be adequately trained" and "Should be wearing appropriate shoes and PPE [Personal Protective Equipment]." This blanket approach to assessing risk indicated the assessments had not been developed to meet people's individual needs.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Another person had been identified as being at risk of falls. There was no risk assessment in place to guide staff on when the person was at risk and what action they could take to minimise the risk. We discussed this with the registered and deputy managers who told us the care plans would be updated to ensure staff were provided with specific guidance on how to manage any identified risk. We visited the person concerned while they were receiving care and saw the care worker was aware of their poor mobility and supported them appropriately.

The service had appropriate emergency plans and procedures in place. For example, staff had access to three pool cars in the event their own car broke down. There was an adverse weather policy in place to

ensure care visits to people with more complex needs were prioritised if necessary.

Any accidents or incidents were reported by the carer involved and documented by the senior member of staff on duty at the time. This meant incidents were recorded soon after the event to help ensure the details were accurate. The reports were reviewed by the registered manager and any necessary action taken to help prevent further occurrences.

We reviewed the service's visit schedules and staff availability and found there were sufficient staff employed to provide all planned care visits. Where staff sickness or high levels of staff leave impacted on staff availability, managerial staff covered shifts to help ensure all planned care visits were provided. The service also operated an on-call system where two senior members of staff each day were available to provide care visits at short notice in the event of staff sickness or other unexpected absences. Staff were provided with uniforms and identity badges so people were able to identify them easily.

The registered manager told us there had not been any missed visits and people confirmed this. If staff were running late they contacted people to let them know. If this was not possible they rang the office who then passed on the information. Where visit locations were a significant distance apart travel time was allocated. Where possible, the registered manager organised staff runs so visits were located in a small geographical area and in these cases staff were not allocated any travel time to get from one visit to the next. This meant staff would either need to leave a visit before the allotted time or be late for the following visit. Daily records showed visits were regularly five or ten minutes shorter than planned. Staff told us this could be problematic and, although they were able to complete all their duties, they felt social interaction with people was sometimes lacking. Comments included; "The jobs get done but they can be rushed", "Sometimes I feel like a headless chicken" and "You can feel rushed into doing things and there's sometimes no real interaction." It is important staff have travel time built into their rotas so people are able to have their care delivered in line with their assessed needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a robust recruitment process in place to help ensure staff had the appropriate skills and knowledge required to provide care to meet people's needs. Staff recruitment files contained all the relevant recruitment checks to show staff were suitable and safe to work in a care environment, including Disclosure and Barring Service (DBS) checks. When necessary the registered manager contacted the appropriate authorities with any concerns regarding people's suitability to work in the care sector.

The service generally supported people with their medicines by prompting or reminding the individual to take their medicines. Staff had received training on how to support people to manage their medicines safely. Medicine Administration Records (MAR) were completed by staff to document when people had taken their medicines. Care plans contained 'medication pen pictures' with details of what medicines people had been prescribed and any other regular homely medicines they took.

Good

Is the service effective?

Our findings

People received care from staff who knew them well, and had the knowledge and skills to meet their needs. A relative told us; "I have every confidence they are aware of [relative's] condition and can handle it." The registered manager told us they tried to ensure people were supported by the same care workers to help ensure continuity of care. They said this was particularly important for those people with more complex needs.

Once appointed, all staff completed a formal induction process which included familiarising themselves with organisational policies and procedures and working practices. Staff new to the care sector were required to complete the Care Certificate. This is a national qualification and designed to give those working in the care sector a broad knowledge of good working practices. Staff then completed 'on the road' training where they accompanied an experienced, senior member of staff on care visits for a period of two to three weeks. During this period a member of the management team asked staff and people for their feedback about the new employee. Once the management team and the new member of staff were confident about their ability to carry out the role they were able to work independently. One member of staff told us; "I asked for extra shadow shifts because I wasn't that confident." The registered manager had agreed to the request.

Staff received regular training in topics including; infection control, safeguarding, food hygiene and manual handling. Where it was identified that there was a need for more specific training to meet people's individual needs this was provided. For example, a group of staff had received training in collar care, [a medical device used to support a persons neck], at a local hospital to enable a person to be cared for at home rather than in hospital. Staff also reported that the management team actively encouraged and supported staff to complete diploma level courses in Health and Social Care. Staff told us the training was good and they felt competent to carry out their roles to a good standard.

Staff received supervision to enable them to raise any areas of concern or discuss training needs. The registered manager and deputy manager told us they were available for staff to talk to if needed and frequently spoke with staff either on the phone or in person. Staff told us they felt well supported. One commented; "There's always someone at the end of the phone." "Spot checks" of staff performance during care visits were regularly completed by the deputy manager. These focused on staff competency in respect of administering medicines and moving and handling.

The registered manager told us they worked closely with district nurses and long term conditions nurses. An external healthcare professional told us; "I do feel that Creative Living give a little bit extra and I wouldn't hesitate putting their names forward, along with other care providers when asked for by clients."

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for 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 their best interests and legally authorised under the MCA. When people live in their own homes any applications to deprive people of their liberty must be made to the Court of Protection. At the time of the inspection no-one was subject to a Court of Protection order. From our discussions with staff and management we found they had an understanding of the need to gain consent from people when planning and delivering care. Training records showed half of the staff team had received training in the MCA before April 2015. This meant they might not have been aware of changes to the legislation which occurred at that time. We discussed this with the registered manager who told us they would ensure training was updated for all staff in the near future.

Care plans provided staff with guidance on how to help ensure peoples nutritional needs and preferences were met. Where appropriate, information about people's food and fluid intake was recorded by staff within the daily care records. One person had been identified as being at risk due to poor nutrition and hydration. We visited the person with a member of staff and saw the care worker encouraged the person to eat and drink in a caring and supportive way. They identified there had been new guidance regarding the person's nutritional needs and delivered care appropriately in line with the information supplied.

Good

Is the service caring?

Our findings

People and relatives were complimentary about care staff. Comments included; "I must admit they are good. I feel like a spoilt brat!", "They're a pleasure to have come in" and "They're very considerate. I appreciate that they take time to speak to my husband as well and make sure he's alright." Care staff were positive about their jobs. One commented; "I love it when I've been in and people are happy and comfortable. I like making people smile."

It was clear from our conversations that the management team and care staff knew people well and had a detailed understanding of people's care needs and individual preferences. Staff spoke about people with fondness and displayed a genuine concern for their health and emotional well-being. For example, it had been identified by staff that one person was becoming increasingly withdrawn. We heard a care worker and the deputy manager discuss how they could support the person to overcome this. The care worker told us; "I'd love to have time to take him out, we'd have so much fun." A relative told us; "We know all the carers and get the same one in the mornings which is important."

Care plans contained information about people's backgrounds and personal histories. This information helped staff to build relationships with people as it identified potential topics of conversation people were likely to enjoy and engage in.

People said care staff respected their decisions and choices during care visits and they were treated with dignity. Comments included; "They are always respectful." We accompanied one care worker on some visits and heard them asking people how they wanted their care delivered and making sure they were in agreement. They were friendly and chatty in their attitude to people while maintaining a professional approach to the actual care tasks.

People's private and confidential information was protected. The management team sometimes communicated with staff using text messages. They told us confidential information was never shared in this way or individual names used. If they needed to pass on information of a more personal nature they telephoned staff to talk to them personally. Staff confirmed to us that information communicated this way was anonymised.

People's preferences regarding how they were supported, were recorded in care plans. For example, one person was keen to maintain as much independence as possible. The care plan stated; "It is important to me to remain as independent as possible" and "Please ask every morning if I require assistance." We visited this person and heard the care worker asking what help the person needed. They told us; "He will quite often tell me to leave the washing up because he wants to do it himself. I don't like leaving it but he really wants to do it." Care plans were signed by people to show they agreed with the content. There was evidence people had been fully involved in their care plan reviews.

People's preferences in relation to the gender of their care workers were respected. If people found they did not get on with particular care workers the registered manager adapted the rota to ensure they were not

supported by that member of staff. During the inspection, one relative contacted the office to discuss a particular care workers approach to their family member. The registered manager explained to us that, although the relative thought the care worker was very good and professional they were very quiet. The relative thought their family member needed bringing out of themselves and would benefit from being supported by a more outgoing care worker. The registered manager immediately started rearranging visit schedules to accommodate this preference.

People were provided with a service user guide when they started using the service. This included a 'who's who' section to help people understand the staff hierarchy. The information was in large print and used simple, straightforward language to aid people's understanding.

Good

Is the service responsive?

Our findings

Before starting to receive a service from Creative Living Care Services a member of the management team carried out a pre-assessment to check they were able to meet people's needs. Information from pre-assessments was used to develop care plans for each person outlining descriptions of the support people needed. The member of staff who had carried out the pre-assessment would then do the initial visit to determine the accuracy and relevance of the care plan. Care plans were regularly reviewed to help ensure the information was up to date and relevant. The registered manager told us reviews occurred at least annually and as and when required in response to any change in needs. People and their relatives, where appropriate, were fully involved in the development of care plans and any reviews.

Some of the care plans lacked detail. There were limited descriptions about people's routines and any house hold tasks staff were required to complete. The review notes in one person's care plan contained information regarding completing laundry and supporting the person when they were ill. However, this depth of detail was not reflected in the main care plan.

Some care plans contained old information alongside the more up to date information which meant it could be difficult and time consuming to identify the most up to date sections. Although reviews were taking place the updated information was not always immediately obvious. Information about visit times was confusing and it was hard to ascertain exactly when people should receive a visit and the duration of the visit. We discussed this with the registered manager who said they would reorganise the documentation to ensure the most relevant information was immediately accessible for staff.

We recommend that the service seek advice and guidance from a reputable source, about developing care plans which reflect people's individual preferences in relation to how their care is delivered.

Other care plans had more descriptive information to help staff meet people's needs according to their preferences. We asked people if they received care and support in a way which suited them. People told us they felt in control when receiving care and were able to direct how care was delivered. One person told us; "If anyone new comes they always ask what I want done and in what order, I'm in charge." During a visit we heard the care worker ask; "What would you like me to do first?"

Daily care records were completed by staff at the end of each care visit. These recorded the arrival and departure times of each member of staff and included details of the care provided, as well as information about any observed changes to the person's care needs. During a visit to one person we saw new information for staff on how to support the person was highlighted at the front of the daily notes. This meant staff had access to relevant information when delivering care.

People and their relatives told us the service was flexible in their approach and able to alter visit times according to people's needs. One relative commented; "I sometimes need extra visits and I've given them long notice and short notice, it's never been a problem."

People understood how to raise any concerns or complaints. One relative said; "I would phone without any hesitation." The registered manager told us there were no on-going complaints. No-one we spoke with had any concerns. A relative told us any concerns they had raised had been dealt with quickly and to their satisfaction. They commented; "To be fair they have been very quick to deal with anything."

Requires Improvement

Is the service well-led?

Our findings

There were two registered managers in post at the time of the inspection. One of these was also the provider and nominated individual. They had stepped down from the managerial role and told us they would submit a notification to CQC cancelling their registration as manager. The service was led by the second registered manager who was directly supported by a deputy manager and a supervisor. There was also a senior care co-ordinator with responsibility for the rotas. The registered manager told us each member of the senior team had clearly defined roles.

The service was registered to support people with a sensory impairment or physical disability. The statement of purpose stated they were also able to support people with dementia, mental health problems and people with a learning disability and some people with these conditions were receiving a service. We discussed this with the provider who told us they would update their registration immediately to accurately reflect the service being provided.

Systems to gather views of people and staff were not robust. Surveys were circulated to people to gather their views of the service although this had not been done since mid-2015. The registered manager told us they were aware this was overdue and were planning to send out surveys in the next few weeks. We looked at the results from the last service and saw these were mainly positive. However, no formal analysis of the responses had been carried out. This meant any trends could have been overlooked.

Some staff meetings were held but these were infrequent. The registered and deputy managers told us they could be difficult to arrange as some staff were reluctant to attend. The last one had taken place in June 2016. This meant staff did not have a regular opportunity to get together with colleagues to share best practice and experiences. This is particularly important for services such as these when staff are often working alone. Meetings for small staff teams supporting people with complex needs who had large care packages were held more often.

As outlined in the 'safe and 'responsive' sections of this report risk assessments and care plans had not been developed to reflect peoples individual needs and preferences.

The registered manager tried to be flexible to accommodate care worker's needs. They told us they valued their staff team and worked to retain good staff where possible. To provide an incentive for staff they had a purchased a corporate membership at a local gym which meant staff and their immediate families could have gym membership at a reduced rate. Staff told us the registered manager was supportive. One commented; "They are very understanding of my family commitments."

On starting employment staff were issued with a staff handbook containing the organisations policies and procedures and information about working practices. There was also information on specific conditions to help staff gain an understanding of some of the issues they might encounter when supporting people.

There were quality assurance processes in place to help the registered manager monitor the service

provided. Staff completed daily notes following each care visit which included details of any issues or concerns identified. These reports were reviewed by the registered manager or another senior staff member. This meant they were able to highlight any issues. Both the registered manager and deputy manager occasionally covered shifts and delivered care which enabled them to keep up to date with the day to day running of the service.

The registered manager had a clear vision for the development of the service which was focused on being able to deliver a personalised service. They told us they did not want the service to become; "massive" because; "I like the personal touch and we're able to offer that. We know all of our people and all of our staff." The management team regularly attended the Dignity of Care forum held by Plymouth City Council in order to keep up to date with any developments in the care sector.

People and relatives told us they were able to contact a senior member of staff when they needed to. One relative commented; "Any problems I can ring the office and they'll sort things out."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people did not consistently meet their needs. Regulation 9(1)(b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. Risks to peoples health and safety were not assessed. The registered person was not doing all that was reasonably practicable to mitigate identified risks. Regulation 12(1)(a)(b)