A Class Care Limited

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Inspection report

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26 February 2018

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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

A Class Care Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service, including a 'live in' care workers service (this means that there are staff supporting people 24 hours a day, seven days a week) to both older and younger adults.

At our last inspection carried out on 11 February 2016 we rated the service good. At this inspection on 14, 15 and 26 February 2018 we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Why the service is rated good.

The Care Quality Commission (CQC) records showed that 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.

Staff had an understanding of the Mental Capacity Act 2005 (MCA). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Staff knew how to report any suspicions of harm and poor care practice.

People were assisted to take their medication as prescribed. Processes were followed by staff members to make sure that infection prevention and control was promoted and the risk of cross contamination was reduced when supporting people.

Staff assisted people in a caring, patient and respectful way. People's dignity and privacy was promoted and maintained by the staff members supporting them.

People and their relatives were involved in the setting up and review of their or their family member's individual support and care plans. People were supported by staff to have enough to eat and drink.

People were assisted to access a range of external health care professionals to maintain their health and well-being. Staff and external health care professionals, would, when required, support people at the end of their life, to have a comfortable and as dignified a death as possible.

People had individualised care and support plans in situ which documented their needs. These plans informed staff on how a person would like their care and support to be given, in line with external health and social care professional advice.

There were enough staff to meet people's individual care and support needs. Individual risks to people were identified and monitored by staff to allow them to live as safe and independent a life as practicable. Staff were only employed within the service after all essential checks had been suitably completed. Staff were trained to be able to provide care which met people's individual needs. The standard of staff members' work performance was reviewed through spot checks, supervisions and appraisals.

Compliments about the care and support provided had been received. Complaints received were investigated and responded to. Actions were taken to reduce the risk of recurrence. The registered manager sought feedback about the quality of the service provided from people. There was an on-going quality monitoring process in place to identify areas of improvement needed within the service.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

A Class Care Limited

Detailed findings

Background to this inspection

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

This comprehensive inspection took palace on 14, 15 and 26 February 2018 and was announced and was undertaken by one inspector. We gave the service 48 hours' notice of the inspection visit because the location provides a domiciliary care service and we needed to be sure that staff would be available.

Inspection site visit activity started on 14 February 2018 and ended on 26 February 2018. It included visits to the office, a visit to a person using the service at their home and telephone calls. We visited the office on both 14 and 26 February 2018 to see the registered manager and office staff; and to review care records, policies and procedures and records relating to the management of the service.

Before our inspection we looked at all the information we held about the service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about. We looked at the provider information return (PIR) which was submitted to the Care Quality Commission on 12 January 2018. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.
We asked for feedback from representatives of a local authority contracts team, Healthwatch, and a local clinical commissioning group. Information received was used in planning this inspection.

During our inspection we spoke with five people (four by telephone) and two relatives of people using the service by telephone. We also spoke with the company director/ registered manager, another company director, a case manager who also provides care, two live in care workers and a community care worker. We spoke with a social worker by telephone.

We looked at three peoples care records; records relating to staff recruitment and training; compliments and complaints; accidents and incidents; medication administration records; policies and procedures and records relating to the management of the service including audits.

Good

Is the service safe?

Our findings

The service remained good because people and their relatives told us that they or their family member, felt safe. This was because of the care and support provided by staff members. Staff had an understanding of their duty to report incidents of suspected harm or poor care. A staff member told us that, "If I had any concerns I would contact my manager and/or the local authority social worker and CQC." Information on how to report a concern was included in people's care records. This was for people, their relatives and staff to refer to if needed. This demonstrated to us that there was a process in place to safeguard people from harm.

People's individual assessed risks had been identified to reduce the risk of harm. This was used by staff as guidance on how to support people, whilst promoting and maintaining people's independence. We saw that environmental risk assessments were in place and technology was used, when required to support people to receive safe, care and support. The information in people's care records was held securely within the office and within people's homes.

Required checks were carried out to make sure that all new staff were of good character. Staff told us that these checks were in place before they could start work at the service. This showed that there was a process in place to make sure that staff were deemed satisfactory and suitable to work with people.

The registered manager told us that there were sufficient staff employed to meet people's care and support needs. The service worked to a tolerance of plus or minus 30 minutes either side of people's agreed care call times. People told us that there were no missed care calls and staff arrived 'mainly' on time. They also told us that they were often supported by the same staff members, who got to know them and their wishes. One person said, "The carers [staff] are on time." A relative told us, "Timekeeping of care calls have been better in the last couple of weeks, before then it could be quite up and down. If [staff] are going to be late they will let you know."

The majority of people we spoke with managed their own prescribed medication. People, who required additional support with their medication, told us that they had no concerns. One person said, "[Staff] make sure I take my medication." Staff told us that they were trained to administer medication and that their competency to do this was checked during a regular 'spot check' by a more senior staff member.

Staff told us and records showed that they have received training in the prevention of cross contamination, infection control and food hygiene. Staff confirmed that there was enough personal protective equipment (aprons and gloves) for them to use and that these were single use items only. This showed that there was a process in place to reduce the risk of infection and cross contamination.

Staff were aware of the reporting procedure and records were held in relation to any accident and incidents that may have occurred. Actions were taken as a result of learning from the incident, these were shared with staff at team meetings to help reduce the risk of recurrence. For example, at a recent staff meeting discussions were held regarding improvements needed when completing a medication administration

record. This showed that learning was used to improve the quality of the service provided.

Good

Is the service effective?

Our findings

The service remained good because people were supported with their care needs in line with 'good practice' guidance and current legislation. This information was reflected within people's care records as information to guide staff. The registered manager also told us that they subscribed to different external organisations for 'email alerts' to keep up-to-date with legislation.

Staff completed training to ensure that they had the right skills and knowledge to provide the individual care and support people needed. Staff told us that 'refresher' training was completed on a yearly basis to update their knowledge. Staff were supported with supervisions, spot checks and yearly appraisals. These occasions were used to develop staff skills through training and assessments. When new to the service staff had an induction period. This included training and shadowing a more experienced member of staff. This was until staff were deemed competent by the registered manager to provide care.

The majority of people spoken with did not require the support of staff with their eating and drinking. For people who required this assistance, staff demonstrated their understanding of supporting people who required a specialised diet due to a risk of poor swallowing or due to a specific health condition.

The service worked with external organisations to ensure that the best possible quality of service was provided. For example, working with the local clinical commissioning group and or people's assigned social workers. A social worker told us of an example where staff from the service worked with them and other health professionals to move a person from a care home back into their own home. They said, "From the start there was a co-ordinated response from [staff at] A Class Care Limited." This meant that the service met people's individual care and support needs.

People who needed support from staff members to set up or to help them attend external health appointments had no concerns around this level of support given. One person said, "Staff monitor my well-being. They recently realised that I was not well and notified the office." They went on to tell us that following this a GP appointment was made. This showed us that people were supported to access to health care service when needed.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Staff were knowledgeable in relation to the application of the MCA. They told us how they used visual prompts to aid people, who may have had fluctuating mental capacity, with their choices. For example showing people the choices of clothes or meals available, rather than just asking a person their choice. The PIR stated that there was no current requirements to request an application be made to restrict a person's liberty to the Court of Protection. This demonstrated to us that consent to care was sought in line with legislation.

Good

Is the service caring?

Our findings

The service remained good because people and their relatives were happy with the care provided and how staff treated them or their family member, when supporting them. One person said, "It's good, I get a lot of help. Staff are flexible and have adjusted care call [times]…for a period of time when I came out of hospital to meet my needs as I needed more help. They were very good." Another person said, "[Staff are] very caring... The [staff] do everything that I ask them. If I forget something I can call them back to help. I receive a good service."

People and their relatives told us that they or their family member, were involved in making decisions about their care. And were able to make their own choices and were encouraged to express their views and be listened to. People and their relatives were aware of the care records held within their or their family member's home. A person told us, "Office staff [from the agency] regularly come out to visit to ask for [my] feedback." A relative said, "[Family member] is involved in his care decisions. If he wants something he will say. [Office staff] also ring me once a month to ask for my feedback on the service." Where people were unable to sign to agree their care plans we saw that they were represented by their next-of-kin.

Advocacy was available for people, on request, if they needed to be supported with this type of service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Staff respected and promoted people's privacy and dignity when supporting them with personal care. Care records we looked at that had clear prompts for staff to respect people's privacy and dignity at all times. One person said, "My privacy and dignity are protected by staff." A relative confirmed that, "Staff are friendly, respectful and treat [family member] with dignity," when supporting them.

Care records showed that staff were prompted to respect people's choices and to assist people to maintain their independence. This was confirmed by the people we spoke with. One person said, "[Staff] encourage me to do things for myself."

Good

Is the service responsive?

Our findings

The service remained good because people and their relatives confirmed to us that staff had a good understanding of their care needs and that these needs were met by staff.

People's individual care and support needs were assessed prior to them receiving personalised care. This was to make sure that staff had the skills and knowledge to meet people's requirements. A relative said, "[Staff] did a pre assessment before we used the service to get to know what support was needed." These assessments were then used to develop people's care and support plans and risk assessments. These documents included information for staff on people's care and support needs, their preferences and any health, physical and emotional requirements.

Daily notes were completed by care staff detailing the care and support that they had provided. We noted details in place regarding the person's family contacts, doctor, external health care professionals and assigned social worker (where appropriate), as guidance for staff. Individual preferences also were recorded and included how a person wished their care to be provided, their future goals and what was important to the person.

The support that people received included assistance with personal care, with their prescribed medication, preparation of meals and drinks, social activities, household chores and health appointments. We noted that where required, staff supported people with their interests and links with local communities. One relative told us that to promote their family members well-being, "[Staff] try to encourage [family member] to go out and about more for walks in the community. They hired him a wheelchair and they went out recently. I think he enjoyed it."

People and their relative's felt confident in raising any suggestions or concerns they had with the office staff and that they would feel listened to. One relative said, "I feel confident that the office staff would listen if I had a concern. They ask me is there anything we can do to improve?" Complaints records showed that people's concerns were responded to, investigated and actions taken where possible to reduce the risk of recurrence.

A Class Care Limited does not provide nursing care to the people it supports. However, part of staffs training included training in end-of–life care. To support people approaching the end of their life staff would work with the person and their family to make sure that they met their individual wishes, including cultural and religious wishes and people's preferred place of death. They also told us that they would work with external health care professionals, when it became clear that people's health condition had changed or deteriorated. This was to enable staff to support people to have the most comfortable, dignified, and pain-free a death as possible.

Good

Is the service well-led?

Our findings

The service remained good because a registered manager was 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. They were supported by another company director, office staff and care workers.

From discussions we found that the registered manager and staff had a very good understanding and knowledge of people's care and support needs, likes and dislikes and future goals. Staff were clear about the expectation of the directors of the service to provide a high quality service that met people's individual requirements. One staff member said, "[The services] values were caring, reliable and to provide quality care." Another staff member told us," There is an expectation of the [directors] that staff deliver a high standard of care [to people]."

People were complimentary about the service provided, the staff and how the service was run. One relative said, "I am really happy with A Class Care [Limited]." A person described the service they received as, "Good," and another person told us, "All going pretty well, very good."

The rating of the previous CQC inspection was displayed on the services website. Records the CQC held about the service, and reviewed during the inspection confirmed that notifications had been sent to the CQC as legally required. A notification is information about important events that the provider is required by law to notify us about.

Checks were made to monitor the quality of the service provided. These included the monitoring of complaints received, feedback from people who used the service and their relatives, spot checks on staff and audits of people's daily notes and medication administration records. For any areas of improvement found, actions were taken to reduce the risk of recurrence. Actions included refresher training for staff when required.

The directors, registered manager and office staff had regular contact with people who used the service and their relatives. This was via newsletter, telephone calls, emails and through visits to people at home. Feedback was used to monitor and drive forward the quality of the service provided. The directors and registered manager also used 'innovative' ways to update people and their relatives about the service and shared information. This included articles in the newsletter that explained about the MCA 2005, safeguarding, tips on how to stay warm during cold weather and a request for volunteers for a 'befriending scheme' they were launching. The directors and registered manager was also looking to provide classes on different subjects to aid people and their relative's understanding. This showed us that the service looked to continuously learn, innovate, develop and improve the quality of service provided.

Staff worked in partnership and shared information with other key organisations and agencies to provide good care to people who used the service. This included working with the local authority, local clinical

commissioning groups and safeguarding teams.