Care Outlook Ltd

Care Outlook (Battersea)

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?	Requires Improvement
Is the service well-led?	Good

Overall summary

This inspection took place on 09 December 2014 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

Care Outlook (Battersea) provides personal care for people living in Battersea, in the Borough of Wandsworth.

There was a registered manager at the service. 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.

People that we spoke with did not raise any concerns about their safety. The provider took appropriate steps to try and ensure people were kept safe through delivering safeguarding training to staff and following correct procedures when concerns were raised. The provider took action when concerns were raised and worked with other agencies to ensure people were kept safe.

Summary of findings

Recruitment checks were completed prior to care workers starting work at the service including criminal record checks. They completed a comprehensive induction and shadowed more experienced staff before they started to deliver personal care independently. The induction covered a number of areas including the values of the organisation and their responsibilities as a care worker. They were given training in relation to maintaining safety at work and meeting the needs of people using the service. They were provided with ongoing training thereafter to ensure they were kept up to date with current practice. Staff told us they received appropriate training and felt well supported through regular supervision.

A quality monitoring officer completed individual risk assessments for people using the service and these were reviewed regularly. They included the action staff needed to take to minimise the risk. Each person had a medicines risk assessment and a fire safety risk assessment. The provider took a proactive approach to managing risks. For example, staff supported people to have smoke alarms fitted in their homes.

People's dietary needs and preferences were recorded in their care plans. Care workers told us they notified the manager if they had any concerns about people's health and we saw evidence of this in people's care plans. We also saw that referrals had been made to people's GPs following a fall or when a change in their needs was noted.

Where possible, people were given regular care workers which helped them to develop caring relationships. There was evidence that language and cultural requirements were considered when allocating care workers to people using the service. Staff told us about the importance of respecting people's privacy and dignity in relation to carrying out personal care for people. People were given the choice of whether they wanted a male or female carer and the provider respected this.

People's needs were assessed regularly to ensure their needs could be met. An initial assessment was completed from which care and support plans were developed. A six week review was held to ensure the support needs of people were being met.

The provider took action when formal complaints were received to try and improve the service. Appropriate action was taken, for example more training delivered if required. However, informal concerns were not captured as effectively by the provider.

Robust quality monitoring visits took place which included unannounced spot checks, observations, monitoring of time keeping and learning from complaints.

Summary of findings

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 was safe.

Care workers attended safeguarding training and were aware of what steps to take if they had concerns.

Risk assessments were carried out before care was provided to people and were reviewed as and when the need arose.

The provider took appropriate steps to ensure robust staff recruitment procedures were followed and there were sufficient staff to meet people's needs.

People received their medicines safely and care workers had attended training in the safe administration of medicines.

Good

Is the service effective?
The service was effective.

Care workers attended a comprehensive induction before they started to deliver care and thereafter received ongoing training which met the needs of people using the service.

People's dietary requirements were met. People who required extra support when eating had their needs recorded in their care plan and staff followed the appropriate guidelines.

Care workers took appropriate steps if they noticed people's health needs had changed, such as contacting the GP or raising these concerns with the managers.

Good

Is the service caring?
The service was caring.

People's cultural needs and wishes were considered when delivering personal care and the provider made attempts to match people with care workers who were aware of any specific cultural requirements.

Care workers were aware of the importance of privacy and dignity when delivering personal care.

Good

Is the service responsive?
Some aspects of the service were not responsive. Although formal, written complaints were responded to in a timely manner and to the satisfaction of people using the service, the service needed to improve on how it acted upon informal concerns or suggestions from people using the service

Requires Improvement

Summary of findings

A quality monitoring office carried out a needs assessment to ensure people's needs could be met. Care plans were arranged in an easy to understand layout.

Is the service well-led?

Good

The service was well-led.

Care workers told us they felt well supported by the management team and enjoyed working at the service. The manager received good support from a team consisting of a care co-ordinator, a quality monitoring officer, administrative staff and also from a regional manager.

A number of quality assurance checks were completed to ensure people received a good service.

Care Outlook (Battersea)

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 9 December 2014 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection was carried out by two inspectors and an expert by experience who carried out telephone interviews with people using the service after the inspection. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service and safeguarding alerts raised. We asked the provider to complete a Provider Information Return (PIR) prior to our inspection. The PIR is a report that providers send to us giving information about the service, how they meet people's needs and any improvements they are planning to make.

We spoke with 15 people using the service, six relatives and nine staff members including the registered manager, five care workers, the quality monitoring officer, the trainer and the senior care co-ordinator. We looked at records including six care records, training records, staff supervision records, medicines records and audits. We also contacted local authority commissioners and the local safeguarding team to gather their views about the service.

Good

Is the service safe?

Our findings

People that we spoke with did not raise any concerns regarding their safety. Care workers had completed training in safeguarding adults during their induction, thereafter it was refreshed every year. Some care workers we spoke with were not clear about what the term 'safeguarding' meant. However, during our conversations with them it was evident that they were aware of what to do if they had any concerns and knew how to identify different types of abuse. There was evidence that the provider raised safeguarding concerns with the safeguarding team at the local authority.

Staff followed guidance with regards to reporting safeguarding concerns. We saw recorded incidents and accidents where care workers had notified the manager of any concerns they had identified when providing care for people. They completed incident forms when required and these were followed up and appropriate action taken. For example notifying the local authority and completed body maps if any bruises were found when carrying out personal care for people.

Risk assessments for people using the service were completed by a quality monitoring officer. They were comprehensive and considered factors such as access, premises, tasks and equipment. Each factor had an associated hazard and the action needed to minimise the risk. In addition, each person had a medicines risk assessment and a fire safety risk assessment. These were completed prior to the package of care starting or within 48 hours. There was evidence that the provider took a proactive approach to managing risks to people. For example, where staff discovered people didn't have smoke alarms fitted in their home, the fire brigade was contacted to provide these for people, if they consented to this.

The provider took steps to try and ensure people were kept safe through the robust recruitment of staff. Staff completed an application form, attended an interview and had to provide evidence of their identity, proof of address, written references from previous employers and criminal record checks.

Staff told us they were given time to travel between visits and felt that the time allocated to people was sufficient to meet their personal care needs. People were allocated care workers who were familiar with their needs and had provided care for them previously in cases where staff were required to provide cover due to annual leave or sickness. Staff told us that if they were part of a 'double-up' where two care workers were required, they were never left to carry out their duties by themselves.

Care plans contained a medicines assessment sheet. This included how the person's medicines were dispensed, if there was a risk that the person may become confused about when they were supposed to take their medicines, where the medicines were stored, and whether any family or next of kin were assisting with the medicines. This demonstrated that the provider took into account people's ability to self-administer medicines and provided the level of support they required.

Staff confirmed they had attended training in administering medicines which was reflected in the training records that we saw.

Good

Is the service effective?

Our findings

A person using the service told us, "My carer does my personal care in the morning and is very well trained and patient."

Staff completed a four day induction when they first started employment with the service. This was a comprehensive programme covering issues relating to staff employment such as work hours, leave, pay and code of conduct. Training was also provided as part of the induction which was a mixture of classroom based sessions and more practical skills such as safe manual handling and use of equipment such as hoists. Staff were given training about understanding the experiences and particular needs of people who used the service, including dementia, continence management and personal care tasks. Staff also received training in maintaining safety at work, which included topics such as dealing with violence and aggression, hygiene and infection control, emergency situations and lone working.

Refresher training for mandatory subjects was provided for all staff in safeguarding, moving and handling, medicines and health and safety. Other training was provided if the need arose. New staff shadowed experienced care workers before being allowed to work independently. One staff member said, "I stood and watched and saw how they [experienced care workers] did the job." There were two regional trainers for the provider who delivered all training to staff. During our inspection, new staff were undergoing their induction training.

Some of the comments from staff included, "the training was good", "It's good to have refresher training", "I learnt a lot of things in training, hoisting and dementia care."

Staff told us they felt supported and were given the opportunity to speak with their manager through formal methods of supervision and appraisal. Face to face supervisions were held every three months and an annual appraisal of performance was completed. In addition, staff were supervised 'in the field', whilst in people's homes to ensure they were following correct moving and handling techniques and were assessed on their punctuality, communication and general conduct.

We spoke with staff about their induction, training and ongoing support. They told us they found the induction programme useful and said it prepared them adequately for their role. They said the level of training was good.

Staff told us they always asked for people's consent prior to providing personal care for them. They told us that people sometimes needed encouragement when having personal care needs met, and that they respected people's right to say no. There was evidence in the care plans that people were asked for their preferences with regards to how they wanted aspects of their personal care to be carried out. Where appropriate, the views of people's relatives were sought when assessing risk and developing care plans. Staff received training in people's right to make informed choices for themselves.

Some people required care workers to support them with meal preparation. People's dietary preferences with regards to what they liked to eat were recorded in their care plans and staff told us they referred to these. The care plans that we looked at had details of what people liked to eat and the level of staff support needed. People who were at risk of choking and required food to be softened also had their needs met and there were written support plans which informed staff about people's needs.

Staff were familiar with the dietary requirements of the people they supported. Where they were required to prepare meals for people, they respected people's preferences as stated in their care plans or asked them or their family members what they preferred.

Care workers told us they notified the manager if they had any concerns about people's health. They gave us examples where they had noticed people had become less independent and required more support. They told us they had spoken with the manager who had taken appropriate action. We saw evidence that the quality monitoring officer had undertaken a home visit and carried out a joint assessment with social services where care workers had raised concerns as a result of people's changing needs. Staff had also made referrals to people's GPs following falls or when a change in their needs was noted.

Good

Is the service caring?

Our findings

Comments from people using the service included, “My carer does housework for me and is very polite and a good timekeeper” and “I now have a carer who comes regularly and one I can trust.”

Staff told us that they were assigned as regular care workers for people. They said this helped them to develop caring relationships with them as best as they could in the limited time that they had with them. Developing positive relationships was covered in staff induction as a topic and care workers told us that they did have time to speak with people in the time allocated and always made an effort to strike up a conversation with them when supporting them. One staff member told us, “I always try and speak with people and see how they are doing.”

Some care workers told us about situations that showed a caring attitude, for example, one care worker said they had noticed a decline in a person’s health which meant the time allocated to them was not sufficient to meet their needs. While they waited for extra hours to be allocated to this person, they continued to stay behind until all their personal care needs had been taken care of. We saw that potential care workers were asked what caring meant to them in the context of their role during interviews. There was evidence that language and cultural requirements were considered when allocating care workers to people using the service.

People were involved in the planning of their care and involved in making decisions about their care and staff offered them choices and respected their wishes. A copy of people’s care plans was kept in their homes, these were written in plain English and were easy to follow. Care plans and risk assessments had been signed by people using the service or their next of kin, indicating their agreement to it. There was evidence that people were able to express their views about their care through the quality monitoring visits that were carried out, either over the phone or in person.

Staff told us about the importance of respecting people’s privacy and dignity in relation to carrying out personal care for people. They gave us examples such as ensuring personal care was carried out in a closed environment, making sure the bathroom doors were shut and curtains drawn. Other examples included, not exposing a person’s body if it was not necessary.

People were given the choice of whether they wanted a male or female carer and the provider respected their choice. Male care workers were not allowed to carry out personal care for women. Staff told us that the provider took into account both their own and people’s cultural wishes and respected them.

Requires Improvement

Is the service responsive?

Our findings

We spoke with the manager and the care co-ordinator about the process for accepting new referrals. The majority of people that received care from the provider were commissioned through social services. A referral from social services would contain basic information about the support needs of people including the amount of time allocated and the type of care needed. Based on this information, the provider made a judgement about whether their needs could be met by the service. Staff told us that some of the factors they considered were whether staff were available at that particular time, people's cultural needs and travel time.

In some cases, the care co-ordinator would contact the people or their next of kin if they needed to gather more information about their needs. The quality monitoring officer would then carry out a house visit to complete an initial risk assessment and care plan. People and, where necessary their next of kin were involved in the development of the care plans. The care plans and risk assessments were reviewed after 6-8 weeks to ensure that people's needs had been captured effectively and their needs were being met. This meant that the provider took action to ensure they could provide a service that was responsive to people's needs.

Care plans were well laid out and easy to understand. Each care plan contained a support plan information sheet which had details of important information about people such as the next of kin contact, their GP, any identified health issues, living arrangements, sensory information, and their level of communication.

Support plans were written in clear English, which staff told us they found easy to understand and follow. There was evidence that the provider considered people's preferences with regard to how they wanted staff to support them. Each support plan had details of the 'task' that was to be competed, the 'detail' about the task and 'personal routine' which recorded people's preferences.

Some relatives told us that on occasion they had contacted the office to raise issues and that staff had made positive changes to the care provided. Some people told us that care workers turned up late however, this feedback was not reflected in the reports that we saw from the electronic monitoring system during the inspection and from feedback we received from the contract monitoring department at the local authority as being an underlying concern with the service.

All formal, written complaints received from people using the service, their relatives or via the commissioning team at the local authority were overseen by the regional management team. Complaints were analysed to monitor trends, inform learning and improve the service.

We looked at the record of complaints received in the past year. Complaints were arranged so that it was easy to track the progress of them and whether they had been resolved to the satisfaction of the complainant. The provider responded to complaints in a timely manner, thorough investigations took place which included speaking to staff and checking records such as time sheets where the complaint was related to time keeping. The provider took action based upon the results of any investigation. In the complaints record, all the complaints had been resolved to the satisfaction of people using the service.

During our inspection some people raised general complaints about issues such as communication and time keeping. We did not see any evidence to confirm this during our inspection or receive any negative feedback from healthcare professionals. However, although there were systems in place for gathering more informal feedback from people about concerns that they had for example through quality monitoring visits, these were not always effective in picking up some of the concerns that we received.

Good

Is the service well-led?

Our findings

The values of the organisation were covered in the induction for all staff. The service user guide issued to people using the service gave a summary of the statement of purpose, the philosophy and the aims and objectives of the service.

Care workers told us that the manager and other office based staff were very supportive. They said that they felt comfortable approaching them with any concerns that they had and were given time to speak with them when they came to submit their time sheets. One staff member said, "I feel confident in raising concerns." Another said, "I do enjoy working here." Staff told us that if they witnessed any poor practice taking place they would not hesitate to raise this with the manager.

There was a registered manager at the service. The registered manager was supported by a staff team with specific roles. These included a care co-ordinator, a quality monitoring officer, and other staff responsible for invoices and administration of the 'staff plan' system for co-ordinating care worker shifts and monitoring the timings of the visits. Staff members told us that these clearly defined roles helped ensure the service was managed effectively. One staff member said, "We are a good team, we get great support."

The manager received support from a regional manager who attended weekly management meetings. Team meetings for care staff were held approximately every quarter. Staff told us that whenever the manager was away, they were able to speak with someone from the regional team. This was reflected in the feedback we received from healthcare professionals.

The registered manager was aware of their responsibilities in terms of submitting statutory notifications to CQC informing us of any incidents that had taken place and these were submitted as required.

Health and social care professionals who worked with people who used the service told us that the service was well-led and that the manager was available and took suggestions and concerns on board to try and improve the service.

There were robust quality assurance checks carried out by the provider. Many of these were led by the quality monitoring officer. These included, an initial six week review after a new package of care started to ensure people's needs were being met and to implement any changes if required. In addition, a number of follow up visits were conducted, these included evaluation assessments for all new staff which looked at their punctuality, appearance, communication and conduct. Moving and handling supervisions were also carried out to ensure care workers were able to operate hoists safely. Spot checks were carried out in the case of immediate concerns that were raised by people or their relatives and other monitoring visits were carried out either in person or over the phone. Records of these visits were kept in people's care records. The feedback that we read in these was largely positive.

Daily care records and completed MAR sheets were brought back to the office to ensure they were completed correctly. The time keeping of care workers was monitored through an electronic system which enabled the provider to track any missed or late visits. The provider took appropriate action if a particular care worker was consistently late either through informal discussions or a formal supervision or in rare cases a disciplinary. We saw that the provider was consistently meeting targets agreed with the local authority with regard to the time keeping of care workers.

The provider was a member of the United Kingdom Homecare Association Ltd (UKHCA), which is the professional association of home care providers from the independent, voluntary, not-for-profit and statutory sectors. UKHCA helps organisations that provide personal care to people in their own homes, by promoting high standards of care and providing representation with national and regional policy makers and regulators.