Trust Care Agency Limited

Trust Care Agency

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection took place on 16 May 2017 and was announced. We told the provider we were coming as we needed to be sure the management team were available to speak with us. This was the service's first inspection since it was registered in March 2015. Trust care agency is a domiciliary service which provides personal care and support to people in their own homes. At the time of our inspection there were eight people receiving the regulated activity of personal care.

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.

People received visits from consistent staff at their preferred times and for the duration they had agreed. People were supported by staff who received on-going training and guidance for their roles. Feedback indicated satisfaction with the care provided by staff.

People felt safe using the service and risk assessments were in place which helped staff to keep people safe and mitigate risks. Some risk assessments needed more detailed guidance for staff to follow, but the management team had already identified this as an area for improvement. Other relevant risk assessments, such as those relating to choking and the use of bed rails, needed to be implemented to ensure staff had guidance and people were safe.

People were supported to make their own choices and this was reflected in their care records. The service was reviewing people's ability to make their own decisions, to ensure that the service acted in accordance with the Mental Capacity Act 2005 (MCA) when necessary.

Staff had received safeguarding training to help them to identify any concerns or suspicions of abuse to help protect people using the service. Recruitment checks were conducted appropriately to ensure that people were supported by staff who were suitable for the role.

People were involved in their care planning and their independence was promoted. Care was taken to gather information about people's interests and preferences. Feedback indicated that people were treated with dignity and respect by staff.

People were supported to seek further healthcare support as required to promote their health.

There was a complaints process in place should people or relatives wish to raise concerns.

The registered provider had systems and processes in place to support the safety and quality of the service.

The management team had plans to develop and drive improvement at the service and were receptive to our feedback.

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 consistently safe.

We found that some risk assessments relating to choking and the use of bed rails were not in place to provide guidance to staff and to keep people safe.

People received their medicines in a safe and timely manner. However, protocols were needed for people taking medicines 'when required'.

People were supported by consistent staff who attended calls on time and as planned.

Staff knew how to protect people from abuse, and who to report concerns to.

Is the service effective?

Good

The service was effective.

People were supported to make their own choices and decisions. Some records relating to the MCA required further clarity to guide staff.

People's nutrition and hydration needs were effectively monitored.

People were supported to maintain good health and had access to healthcare support in a timely manner.

Is the service caring?

Good

The service was caring.

People were involved in their care and positive relationships with staff were promoted.

People's independence was promoted and feedback indicated that staff were kind and respectful.

People's dignity and privacy was respected and maintained.

Is the service responsive?

Good

The service was responsive.

Care plans guided care workers in the care that people required and preferred to meet their needs. These were updated in line with people's changing needs

There was a complaints process in place for people and relatives to raise any concerns they had.

Is the service well-led?

Good

The service was well-led.

Staff told us they felt valued and supported in their roles.

Systems were in place to support improvements to the safety and quality of the service.

People, staff and relatives all felt they could raise concerns or issues to the management team, and felt listened to.

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Detailed findings

Background to this inspection

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

The inspection took place on 16 May 2017 was announced and undertaken by one inspector.

Prior to the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also spoke with local safeguarding teams and quality assurance teams.

We asked the provider to complete 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 considered this information to help plan our inspection.

During the inspection we spoke with the registered manager, senior care co-ordinator, and in-service trainer. Following the inspection we spoke with two people who used the service, three relatives, three members of care staff, and two social care professionals.

To help us assess how people's care needs were being met we reviewed three people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, and a selection of records which monitored the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

People's care records included assessments and guidance for staff on the actions that they should take to minimise risks. These included nutrition, hydration, moving and handling and risks that may arise in people's own homes. We saw that some records relating to moving and handling could be more detailed to ensure guidance was clear to the staff providing support. We brought this to the attention of the registered manager who told us they had already identified this as an area for improvement and showed us that that they had started to update some people's records accordingly.

The registered manager told us they were reviewing their range of risk assessments, and showed us a falls risk assessment they were planning to implement where people could be at risk of falling. Although monitoring of risks associated with malnutrition and pressure areas were being recorded within people's care plans, there was not a specific risk assessment in place to determine the likelihood of a person developing a pressure ulcer, or becoming malnourished. Having this in place enables staff to take action as soon as risks are identified.

We found that one person was having their drinks thickened, which would indicate they were at risk of choking. Whilst reference was given to guide staff in how food and drinks should be prepared, there was not a specific risk assessment in place which would guide staff to prevent and/or take action if the person was choking. Some people in the service were using bed rails, but there were no risk assessments in place to ensure people were safe to use these. We discussed this with the registered manager, and following inspection, they informed us that all of the risk assessments were put in place.

There was a 'weekly handover sheet' in place which was used to review documentation logs, risk assessments, and fluid and food charts. This helped the service to monitor people's well-being on a regular basis and identify concerns.

Environmental risk assessments had been completed which identified potential hazards within people's homes, such as checking fire alarms, trip hazards, lighting and access to the property. These ensured that staff and people were aware of risks that could affect them. Key safe codes (which enable staff to enter people's property) were shared with staff securely, ensuring that the address was not noted alongside this. The services' key safe policy highlighted the importance of ensuring the key safe was not on view when entering the code, and that the codes were reconfigured on leaving.

People told us that they felt safe and well cared for by the staff who were visiting them. One person said, "The carers come in, they are fantastic. They lock up when they leave and I feel secure knowing that." A relative told us, "I know my [relative] is safe and well cared for. They [staff] do whatever is needed and more. If [relative] is unwell, they call me immediately".
Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. A staff member said, "I'm always on the lookout for potential abuse, we can come across different situations, physical abuse, financial abuse or emotional. I'd raise it to my manager immediately". Service user handbooks also made reference to abuse,

and gave specific examples of the types of abuse people can experience. This information could help people identify if it was happening to them, and who they would report any concerns to.

The registered manager told us that as the service was relatively small they were able to ensure there were sufficient staff in post to meet the needs of people, and to provide continuity of care. One person told us, "I have two regular [carers], they come like clockwork. If anything changes I'm informed so I always know who is coming". A relative said, "My [relative] has [health condition] and they need to know if there are any changes in the carer. Occasionally this happens, but its ok as [director] phones and tells me so we can prepare [relative]."

Staff had received training in medicines management and undertook annual competency assessments to check their knowledge. People told us they were happy with how staff supported them to manage their medicines. One person said, "They make certain I have my tablets. They sort them all out for me as I have a lot to take. They help with any additional tablets I might need to take too, and they tell me what the tablets I'm taking are for."

People's care records contained a list of their prescribed medicines. This included the dose, route, times to be taken, and whether they were contained in a blister pack prepared by the pharmacy or separately boxed. It also documented who was responsible for the collection of medicines. Medicine Administration Records (MARs) were well completed, and staff consistently signed to show when medicines had been given. Any medicines which were to be administered, for example, every three days, had been highlighted in the relevant MAR to ensure the correct frequency was known by all staff.

For people receiving medicines 'as required' we saw that these were referred to within people's MARs, however, there were no protocols in place for staff to follow on when to offer these medicines. This information is necessary where people may not be able to verbalise how they are feeling. A protocol would provide staff with information on symptoms a person may display if they were in pain. The management team told us they would implement these promptly and were also adding body maps for topical applications that had been prescribed. This will help to ensure correct application.

Good

Is the service effective?

Our findings

Staff received training in subjects relevant to their role. For example, moving and handling, MCA, dementia, safeguarding and medicines management. Training included on-line learning and practical sessions. The service had an in-house trainer who delivered training sessions to staff. The in-house trainer was passionate about the importance of training and told us, "I'm very well supported in my role. Any training I need is also arranged. I deliver practical sessions to staff, and I ask for feedback from them to ensure staff find the sessions useful, and if not I can adapt them". The senior care co-ordinator told us, "Any staff found not to be up to date in their training are sent a reminder by text message and we log this. We take training seriously".

People said they felt confident in the staff approach. One person said, "The carers know what they are doing. You can see they get some sort of training. Even the younger ones seem to know what they are doing, very good". A relative said, "The staff are fantastic. They understand how my [relative] feels and care for them well".

Staff new to the service completed a five day induction, which consisted of mandatory training and shadowing of more experienced staff. One staff member told us, "I've worked here for a few months, but I'm experienced in care work. The induction I received with Trust was very good, my head was buzzing with information". If new staff did not hold relevant qualifications in care, they were expected to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their work. Two staff working in the service had completed the Care Certificate. Staff received supervision sessions every six months, but also had informal chats and practical observations carried out on an ad hoc basis. This helped the management team monitor that staff were competent in their work. One staff member said, "We communicate with the office regularly. Someone is always available if I have any questions, I can ask anything without feeling silly, and they [management team] always deal with things quickly".

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

People's records made reference to people's ability to make decisions, and were signed by people (or where appropriate their representative) to consent to the care and treatment they were receiving. Where legal representatives were in place, these were documented. One person was living with a form of dementia which affected their memory. The record stated that whilst the person had instructed a legal representative to act on their behalf, staff should also consider that the person was still able to make day to day decisions, and that this should be encouraged. One relative told us, "My relative is still very vocal, so if there were any issues [relative] would raise them. I am also consulted though, the agency keep me updated on what's happening with my [relative]. Another said, "They always call me. I know exactly what is going on. My

[relative] has [condition] so needs me to act on their behalf for different things. The staff have called or texted me two or three times a day before to ask about things. It gives me complete peace of mind".

Records included a section on "communication and memory". These reflected the importance of ensuring that the correct communication methods were used to maximise people's ability to understand what was being asked, and that time was given for them to respond. For example, one record said, "Listen attentively to what [person] is trying to convey", and, "[Person] can understand if patience is given". This helped staff to understand individual needs which helped to maximise people's involvement in the delivery of their care. However, records did not always provide guidance to staff as to specific decisions that the person was able to make and the support they needed with other decisions. The registered manager told us they were working on implementing improved documentation with regard to best interests decisions, and being more specific about particular day to day decisions which people could still make.

Staff had received training in MCA, and respected people's ability to make their own decisions. One staff member said, "If an individual has full capacity then they make their own decisions or choices. If people aren't able to make some decisions, a best interests decision can be made on behalf of the person. I would report any changes in a person's behaviour to management so this could be reviewed". One person told us, "The girls [staff] always ask me what I want first, they don't just do it for me, there's a level of respect". A social care professional told us, "They [Trust care agency] certainly ensure people are represented and have a voice. [Management team] have attended meetings before when reviews were taking place to ensure relevant information was handed over".

People's records made reference to their hydration and dietary needs. This included preparation of meals where required, and a record of food and fluid intake where there was risk. People's favourite foods were listed, options for meals, and how they liked their drinks to be served. Where people needed thickened fluids, this was documented. The registered manager told us that instruction on how to prepare thickened drinks were displayed in the kitchen in people's homes to ensure correct consistency. Where people were at risk of developing a urinary tract infection, reference to this was documented for staff, such as reminding people to drink a full glass of water to reduce the risk.

People were supported with access to health care services when required. We saw that referrals to relevant professionals were done in a timely manner, such as SALT (speech and language therapists), physiotherapists, social care professionals, and access to GP services when required.

Good

Is the service caring?

Our findings

People told us that the staff providing their care were kind and attentive. One person said, "I'm very happy with the carers. They know if I'm having a bad day, and they adapt how we do things. They know me well". Another said, "I have two great carers. They look after me well, and we have a laugh and a joke". A relative told us, "They understand how relatives feel as well. It's not about the money for them [Trust care agency], they actually care".

Our discussions with the management team and staff showed that they considered the interests and preferences of people using the service and used these as means to connect with and get to know people using the service. People and their relatives told us they had good relationships with the staff that attended their care. They spoke highly of the attitude of the staff saying they treated them with kindness and compassion. The service kept in contact with family members and representatives, either by arranging meetings with them, or by telephone to ensure effective communication. One relative said, "If in the event that a new carer has to come in, the office tell me so I can prepare my [relative]".

People were supported to express their views and were involved in the care and support they were provided with. Records showed that people and, where appropriate, their relatives had been involved in their care planning. Reviews were undertaken weekly and where people's needs or preferences had changed these were reflected in their records. One person said, "I've read my care plan, when it's time for a review, two staff come in and questions are asked of me, I'm fully involved". People were given details of local advocacy services they could contact if needed, which were listed in the 'user's handbook'.

We saw that people's preferences for who delivered their care was noted. For example, one person's record showed that they had expressed a preference for female carer to attend to their care. Another person commented that they didn't like people who shared their religious beliefs, or who were 'loud' in their character. Having this information enabled the management team to match staff more closely with the person receiving care. People's privacy and dignity was promoted and respected, and care records made reference to the importance of this. People told us that they felt that staff respected their choices about their care. One person said, "We [person and staff] agree what needs doing together. I'm asked my opinion".

People's records also provided guidance to staff on the areas of care people could attend to independently and how this should be promoted and respected. One record said, "Encourage every-day life skills and continual independence. Respect [person's] decisions and choices". This meant that wherever possible the importance of promoting people's independence was considered and support was provided where agreed.

Good

Is the service responsive?

Our findings

People and their relatives told us that the service was responsive to people's needs. One person said, "The carers do all that they can, they are extremely good, they make suggestions to make life easier". A relative said, "The whole organisation is friendly and they sort things out quickly". A social care professional told us, "They [Trust care agency] are flexible. They helped set up a plan for a person who needed consistent carers. They were very helpful".

Prior to any care package starting, the registered manager told us that a member of staff always visited people to carry out an assessment of their needs first. This ensured that the service were able to meet people's needs and plan an effective package of care. Care staff did not provide visits to people until they had met the person and were introduced to them. The registered manager said, "All the carers are introduced to people before they support them. People always know who is coming to their front door". This approach helped people feel more comfortable when staff were visiting them in their own homes.

The service informed care staff of their scheduled visits by means of a rota. One staff member said, "My rota is sent to me, I always know where I'm going and what I'm doing. I get to know people well which is lovely". The registered manager told us that there had been no incidents of missed visits, and if a staff member were to be unavailable, they would step in to cover the visit. A relative told us, "The punctuality of carers is good. Never been late, if anything they turn up before their time".

Records contained person-centred information that had been gathered to guide staff in meeting people's expressed needs, interests and preferences. This included mobility, medicines, eating and drinking, washing and dressing, communication, and religious beliefs. There was also a 'summary' page which described people's particular likes and dislikes and personal interests. For example, important information was included, such as people's preference for the volume setting on the television, and particular television programmes they enjoyed. These details gave staff additional information about what people liked, and could be used as an opportunity to engage people in conversations about things they were interested in.

People's changing needs were identified promptly and care records were updated to reflect this. One relative told us, "We keep a communication book in the home, which we [family members] and the carers use to share information, we write in anything of importance and the carers always read it and respond, the communication is fantastic".

In addition to personal care, people's social care needs were considered, and we spoke to one person who told us that they were supported by staff to go to the supermarket, and that without them they wouldn't have the confidence to go out alone. They said, "I feel safe when I'm out with them [staff]. There are three of them and I met them all before they started supporting me".

There was a complaints process in place for people and others to use if they wanted to comment on the service provided. The service had only received one complaint in 2016, and we saw that this was responded to, with a clear log of correspondence and discussions which had taken place.

People were given a 'service user guide' which described how they could complain, and details of other organisations, such as the local authority. One person said, "I have no complaints, no criticisms at all, but I could raise any issues with [names of directors] and they would respond quickly".

Good

Is the service well-led?

Our findings

The registered manager was also a director of the service, and was fully supported by a second director, senior care co-ordinator and trainer. The team worked closely to share the day to day running of the service, the implementation of quality systems and processes, and future planning. The registered manager told us how the reputation of the service, and the quality of what they provided to people, was very important to them. They said they had not let the service grow too big before all of the improvements they had planned were in place.

Feedback was important to the management team, and we saw that surveys were issued to people and relatives every six months. People receiving care for a temporary period, were also provided with a feedback form so their views were obtained. The registered manager told us that they were informally asking people for their views weekly, and this was an on-going process. We saw two comments from relatives received January and February 2017. One relative said, "After years of unpleasant experiences with so called 'care agencies', it is so refreshing to be able to praise and thank you for supplying wonderful care and support". And, "Trust provides an excellent continuity of care to my [relative], and I would highly recommend it to anybody in need of care". A social care professional told us, "[Registered manager] has a good attitude. They put things in place".

People were also complimentary about the management team. One person said, "They are all pleasant people. Helpful and very good. I've had a good long chat with [director] before". Another said, "Trustworthy, decent, and they do what they say".

Staff were clear about their roles and responsibilities and said they felt valued by the management team. They were enthusiastic, motivated and had confidence in the management team. One staff member said, "They [management team] make you feel valued and let you know when you have done a good job. Each of them [management team] has their own qualities". Another said, "Brilliant [registered] manager, if I call in with a query it gets dealt with straight away. The office is always manned".

Staff were sent information, such as new service policies and out of hours processes, via a staff group email to ensure information was shared in a timely manner. Where new policies were introduced, staff had to confirm they had read these. The senior care co-ordinator had set up a system which monitored staff sickness, training, and supervision dates. The system enabled them to have effective oversight of any issues which may arise, and ensure staff were up to date in their training. Staff meetings had taken place in the service every three months, and we saw the most recent staff meeting in March 2017 had discussed relevant items such as general updates, staff uniform, training, social media, and supervisions.

The systems in place for monitoring and improving the quality of the service were sufficient to enable shortfalls to be identified and for the appropriate actions to be taken to improve the service and ensure the safety of people receiving care. Audits were undertaken which covered areas such as recruitment, care plans, MAR charts, and the quality of the entries in people's daily logs. Where issues had been found, we saw appropriate actions were taken.

Staff observations were carried out, for example, when administering medicines. Though staff competence was being assessed, the service was not using a standardised template for this, which would ensure a consistent approach in relation to what each staff member was being assessed against. The management team said they would implement this, and a standardised tool for the auditing of care plans.

The registered manager showed that they referred to good practice guidelines and guidance from care publications and the Care Quality Commission. They had joined the United Kingdom Homecare Association (UKHCA), which helps organisations that provide care to people in their own homes promote high standards of care. Following this the registered manager introduced a UKHCA handbook to all staff in the service which they described as a portable guide for care staff, covering health and mental health, behaviours, and good practice advice. They said that feedback from staff had been positive, and that staff often referred to it.

The management team were receptive to our feedback during the inspection, and had plans to continue to drive improvement at the service. This included implementing more information into care plans to ensure people's needs were accurately and comprehensively detailed, and ensuring on-going audits were robust and covered various aspects of the service.