The Care Company UK Ltd

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Inspection report

The Care Company Uk Limited
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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

The Care Company UK Limited is registered to provide personal care to people living at home. People receiving the care have a range of needs, which includes learning and physical disabilities.

At the time of this inspection care was provided to 103 people who lived at home.

This comprehensive inspection took place on 2 August 2016 and was announced.

The provider is required to have a registered manager as one of their conditions of registration. A registered manager was in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the agency. 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 were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were supported to take their medicines as prescribed.

People were supported to eat and drink sufficient amounts of food and drink. They were also helped to access health care services and their individual health and nutritional needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. People's mental capacity was assessed and people were able to make decisions about their day-to-day care. Staff were trained and knowledgeable about the application of the MCA.

People were looked after by staff who were trained and supported to do their job.

People were looked after by kind staff who treated them with respect and dignity. They and their relatives were given opportunities to be involved in the setting up and review of people's individual care plans.

Care was provided based on people's individual needs and helped to reduce the risk of social isolation. There was a process in place so that people's concerns and complaints were listened to and these were acted on.

The registered manager was supported by a team of management staff and care staff. Staff were supported and managed to look after people in a safe way. Staff, people and their relatives were able to make suggestions and actions were taken as a result. Quality monitoring procedures were in place and action was

taken where improvements were identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's individual needs were met by sufficient numbers of staff.

People were kept safe as there were recruitment systems in place which vetted prospective employees. This was before they were deemed suitable to safely look after people.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

The provider was acting in accordance with the Mental Capacity Act 2005 legislation to protect people's rights.

Staff were trained and supported to enable them to meet people's individual needs.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by kind and attentive staff.

People's rights to independence, privacy and dignity were valued and respected.

People were involved and included in making decisions about what they wanted and liked to do.

Is the service responsive?

Good

The service was responsive.

People's individual health and social care needs were met.

People's needs were kept under review and their care met their assessed needs.

The provider had a complaints procedure in place which enabled people and their relatives to raise their concerns. These were responded to, to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well-led.

People were enabled to make suggestions to improve the quality of their care.

Management systems were in place to help staff with developing their career.

Quality assurance systems were in place which ensured that people were being looked after in a safe way.

The Care Company UK 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 inspection took place on 2 August 2016 and was announced. It was carried out by one inspector. The provider was given 24 hours' notice because the location provides a domicillary care service; we needed to be sure that someone would be in.

Before the inspection we looked at all of the information that we had about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law.

The provider completed a provider information return (PIR) and sent this to us before the inspection. 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.

Prior to the inspection we made contact with a local authority monitoring officer. This was to help with the planning of the inspection and to gain their views about the management of the service.

During the inspection we visited the service's office where we spoke with the registered manager; the operations manager; one field manager (who was responsible for carrying out people's assessments and management of staff); and four members of care staff. We also spoke with eight people and two people's relatives via the telephone.

We looked at five people's care records and medicines' administration records. We also looked at records in

relation to the management of staff and management of the service, including audits and minutes of meetings.

Good

Is the service safe?

Our findings

We checked and found people were kept safe because of how they were looked after. One person said that they felt safe because of how staff treated them and described the staff as "kind". Another person told us that they felt safe because of the way the staff made sure their home was kept secure. This included ensuring that the code to the key safe was known only to staff. They also confirmed that the code to their key safe was kept hidden from public view when the key safe was closed. One member of care staff described the sequence of how they ensured people's codes for the key safes were 'scrambled'. This was after the keys were taken out and returned to the key safe so that the codes would not be accessible to unauthorised members of the public.

The provider wrote in their PIR how they kept people safe by the "initial and on-going refresher training and assessment training of staff in certain topics. This included safeguarding people at risk…" Members of staff told us that they had attended this training and demonstrated their knowledge about this subject. They were aware of the different types of harm and the correct actions they would take in reporting such incidents. Members of care staff also told us about the signs that people might show if they were experiencing harm. The field manager said, "There would be [skin] marks. Bruising. Or they could be afraid and scared to talk." One member of care staff told us, "The person may have bruising. Or they may become withdrawn. Or not eating or sleeping." This showed that staff were trained and knowledgeable about their roles and responsibilities in keeping people safe from the risk of harm.

We found that recruitment of staff protected people from unsuitable staff. Information in the PIR told us that there were checks carried out to keep people safe from the risk of unsuitable staff. These checks included a Disclosure and Barring Service [DBS], which the provider told us in their PIR were "renewed at least every 3 years". Members of care staff described their experiences of when they applied for their job. This included completing an application form and attending a face-to-face interview. Furthermore, other checks were carried out which included a satisfactory DBS and two written references. One member of care staff added that their two written references were from "previous employers." The field manager also told us about the recruitment process. They said, "We need to have a DBS and two written references. The interview is to see if they [prospective staff member] are compassionate. That they can listen. Whether they genuinely want to help people. In their application form is their employment history. Obviously we ask what they [prospective staff member] were doing when there were gaps in their employment history." Information in the PIR to support this read, "We recruit only those people who can demonstrate a genuinely caring and compassionate nature. We seek examples and previous life experiences during the interview process to verify these qualities which we place above prior care experience and training." In addition to the recruitment process, there was a staff disciplinary procedure in place. This would be carried out when any members of staff were not keeping people safe from the risk of harm.

There were enough staff to look after people and meet their individual needs. This included two members of staff to support people at the same time with their personal and moving and handling needs. One person said that there were "always" two members of care staff to help them transfer by means of their hoist. In addition to this, people told us that members of care staff usually arrived when they should and definitely

stayed the allocated time. Members of care staff said that there were enough staff and that they had the time to travel between visits to people's homes. Occasionally delays were encountered due to unexpected events, such as traffic congestion. One relative told us that any lateness of when staff arrived was a "slight variation" and contributed this to "the traffic". Another person said "The timing [of when staff arrived] has improved." One member of care staff told us how the management team had taken action to minimise the risks of delayed calls. They said, "It is better than it was because management [team] have changed staff rounds. So they [visits] are more together and our calls [visits] are in that one area so we can cover the rounds [scheduled visits]." One person told us that there had been previous problems with staffs' punctuality. They told us that this had now improved and said, "Things have been put right." The registered and operations managers described the electronic system they used to monitor members of staff arrival and departure times to and from people's homes. Records of these demonstrated that people received their visits when these were planned.

There were arrangements in place to cover staff absences and time off to ensure that people received a continuity of care. People told us that they had care from different members of care staff. One relative said, "We usually have the same three girls [care staff] but different ones at the weekend." They explained that the "different" care staff worked alternate weekends and, therefore, there was a continuity of care. They also told us that they did not mind these changes as they had come to know the staff after a time. Another relative said that they had, "Got to know the different staff over the number of years." One person also said, "They [care staff] get to know my ways over a period of time." Another person said that after the first time a member of care staff - who was new to them – the subsequent visits had gone smoothly. They said, "I had to tell them at first. Then after that, it [the care] went okay." The operations manager explained that staff looked after different, rather than the same, people. This helped to ensure that care staff were adaptable in covering staff absences, such as annual leave. One member of care staff said that this way of working ensured that there were enough staff to cover other colleagues' work. They also said that this way of working ensured that people knew different members of care staff. They told us about the advantages for staff in flexible working and said, "It is about learning new routines. Looking after different people. Having different conversations. This helps cover annual leave. It is also an advantage to people as it reduces their stress if they cannot accommodate change [by having a member of care staff who would be new to them]."

People's individual risks were assessed and managed to keep people as safe as far as possible. One person told us that the care staff "always" checked their moving and handling equipment (a hoist) before it was used. They also said that they felt safe because care staff knew what to do when they helped them transfer by means of their hoist. Other risk assessments included those for people's homes and the access to and around the premises. One member of care staff described how they would ensure the risks of trips and falls were minimised by ensuring that items of furniture were not blocking passageways.

People were satisfied with how they were helped with taking their prescribed medicines. Most people told us that they were enabled to remain independent with this. However, when people needed care staff to help them, they told us that they were happy with how this was done. One person said, "I have [prescribed] creams for my legs and feet. The creams go on every day [as applied by care staff]." Medication administration records [MARs] demonstrated that people received their medicines as prescribed. The field manager told us that they carried out audits to check the accuracy and completeness of MARs. Actions were taken to remind staff to complete these if they had not signed the MARs as they should have done. Members of care staff told us that they had attended training in the management of people's prescribed medicines. The field manager told us, however, that trained staff were not able to support people with taking their prescribed medicines unless they were assessed to be competent to do so. Members of care staff confirmed that they were assessed to be competent with this task. The field manager explained the procedure in assessing members of staffs' competencies in management of people's medicines. This assessment

included a final, 'class-room' based assessment. This showed that people were protected as far as reasonably possible from unsafe management of their medicines.

Good

Is the service effective?

Our findings

We found that the provider was ensuring that people's rights were respected in line with the Mental Capacity Act 2005 [MCA]. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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. The application procedures for this in registered services are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered and operations managers advised us that people had the mental capacity to make day-to-day decisions and no person was subject to an authorised DoLS.

Information detailed in the PIR told us how people received care with their consent and this was obtained at the beginning of setting up their care. The PIR read that a member of staff "secures written consent and liaises with the client and their family during the early stages of the contract." The PIR also demonstrated evidence that members of staff had attended training in the application of the MCA. The field manager was able to demonstrate their knowledge in relation to the application of the MCA. They said, "People are assessed to have [mental] capacity unless proven otherwise." One member of care staff said, "[The MCA] is whether you have the ability to make decisions for yourself." The registered and operations managers advised us that they had previously worked with members from health and social care organisations. This was to support people in making decisions, as part of the MCA 'best interest' decision making process. One member of care staff confirmed that this was the case. They said that, historically, "[Best interest] decisions have been made by social workers, the management team and relatives." In the care records that we looked at we found that people were assessed to have the mental capacity to make decisions about their day-to-day care.

The provider had systems in place to make sure that staff were trained and supported so that they had the competence and confidence to do their job well. The provider's PIR read, "Carers undertake shadowing visits with experienced carers and supervisors before being assigned to any client to ensure they are competent and skilled and to orient them to each client's individual needs and preferences." Members of care staff told us that, as part of their induction, they watched more experienced members of care staff and were also observed before they worked alone. One member of care staff explained that 'shadowing' was "to observe how other staff interacted with individual clients [people who use the service]. Everyone is different. And see all the care in action. In people's homes. Getting 'exposed' to that and seeing how to do it." This was so that people were looked after by members of care staff who were assessed to be competent and confident to do so.

The PIR detailed how staff were trained and supported to provide people with their individual care needs by

receiving "comprehensive on-going training includes specialist skills such as PEG [artificial feeding tube] feed, Stoma care, diabetes and blood glucose monitoring. Members of care staff told us that they had attended a range of training which included health and safety and dementia awareness. One member of care staff told us that they had benefitted from the dementia awareness training as they had learnt the different types of dementia. Another member of care staff expanded on this and told us how they applied their knowledge to their practice. They said, "You need to stay patient. Listen and not try to speak for them. [If a person told me something that I knew was not right], I would not challenge them. In their minds they are 100% correct. You "jump" into their world." Members of care staff also told us that they had attended moving and handling training which included the practical use of moving and handling equipment. The field manager told us that this training method was also applied to improve staff members' awareness of people's communication needs. They said, "Role play is promoting listening more than you speak. The staff understood then what people really want, not what we think they want." One member of care staff said, "Role playing can help you sympathise with the person and how it can feel [when being transferred by means of a hoist]." People told us that they were confident in the staffs' ability to look after them. One person said, "I feel the staff are definitely trained. They know what they are doing."

People were looked after by staff who were supported to do their job. The provider wrote in their PIR, "We have a continuous programme of regular planned and unplanned supervision visits for all our carers..." Members of care staff confirmed that their standard and quality of work were assessed during unannounced 'spot' checks carried out by a member of the management team. One member of care staff said, "They [observer] do not tell you when they are coming. They look at how you interact and chat. Your punctuality. They [observer] fill in a form and we can look at it later, for feedback." Another member of care staff said that, although they did not receive feedback, they felt that they would if there were deficiencies in the standard and quality of their work. In addition to 'spot checks' staff members were also supervised on a one-to-one basis. The field manager and members of care staff described the areas that were discussed. These included the health and well-being of the supervisee and their training and development needs.

To ensure that people were supported to maintain their nutritional health the provider told us in their PIR that, "We have introduced Nutrition & Hydration charts for vulnerable clients [people who use the service] to monitor food and fluid intakes." People told us that, unless they were able to prepare food and drink, members of care staff helped them with this. One person, for example, told us that they needed help with getting their meals. They said that staff asked them what they wanted to eat and drink and made sure that they had enough food and drink. They added, "The staff always leave me with a drink of squash. Or something else [to drink]."

People told us that they were independent in making their own health care appointments. However, one person said that if they were unable to do this, they were confident that members of staff would help them. They said, "If I got really desperate the staff would help me [to get a GP]."

The registered and operations managers said that they had previously consulted community mental health professionals when people's mental health needs had warranted this health care input. The field manager also told us that they had visited people's homes when an occupational therapist [OT] was present. This was, for example, when the OT prescribed a change of moving and handling equipment to support a person's increased level of moving and handling needs. One member of care staff told us that people had access to dietician services. They said, "There is paperwork [advice] from the dietician that is kept in the person's folder [care plan]." One person told us about the health benefits they gained from their care. They told us that their three visits per day "helped break up the day." Another person told us that if they did not have the care they would need to be looked after in a care home. They said, "There is nothing like being in your own home. With your own pictures and your own memories." This showed us that people's individual

health and social care needs were met.

Good

Is the service caring?

Our findings

The provider told us in their PIR how they ensured people were looked after by staff who were kind and caring. "During the probationary and training period we evaluate carefully each new carer's interactions with our clients [people who use the service] to determine whether they are patient, compassionate and dedicated to promoting the well-being of our clients." People had positive comments to make about the staff; we often heard the description of "kind." One person said, "The staff are all very nice." Another person said, "The care staff are very polite and do anything I ask them."

People's rights to independence and choice were valued and respected. One person told us that they maintained their independence with food preparation and taking their prescribed medicines. Another person told us how they were encouraged to be independent with their personal care. They added that "staff do my back and legs" as they were unable to do this independently. A third person told us that the staff were "sensitive" when helping them with their continence aids. One relative told us that members of care staff always asked their family member if they wanted a shower or bath.

Members of care staff told us what they considered to be the purpose of their role in looking after people. One member of care staff gave an example of how the care helped a person's self-esteem. They said, "The care was about building the trust and confidence [in the person]. It's also about [person] keeping their pride." Another member of care staff said, "I love my job. Knowing I can help someone live the life they want to live. Helping people stay at home, rather than go into residential care." One person said that the care kept them at home, where they had lived for over thirty years.

The operations manager described the aims of people's care. They said, "One of the most important things is preventing [people's] social isolation. Just making a difference. It's not just about having a wash or personal care. The operations manager also told us that plans were in place to enable people to meet each other in a community setting. The registered manager told us that this venture would be "at no extra cost" to people. To reduce the risk of social isolation and increase people's contact with the community, the field manager advised us what other actions had been taken. This included using a charity which provided a 'befriending' service for people if they chose to take up this offer.

People, including their relatives, told us that they were involved in the reviewing of their planned care. When it was possible, people had signed to confirm that they had been consulted in developing and reviewing their care needs.

The field manager told us that advocacy services were not currently used but was aware of charitable organisations who offered such services. Advocacy services are organisations that have staff working for them who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

People's needs were assessed and were met. The provider's PIR demonstrated how people's needs were assessed and reviewed by, "conducting an extensive care needs assessment in conjunction with the client [person who uses the service] and their family/representatives. We use outcome focused approaches to identify not only the tasks that should be performed at each care visit but also our client's interests, preferences and aspirations. We set measurable targets around attaining such goals. We prepare a detailed written care plan which is delivered to the client's home and reviewed with them." People told us that they had been involved or their relatives on their behalf, in the assessment of their needs before they started the care. People also said that they were satisfied with the care. One person told us that they "couldn't do without it [the care]." Another person told us that the standard and quality of their care was "better" than when they were looked after by a relative. They told us that this was because staff checked the condition of their skin, to make sure it remained healthy.

The provider told us in their PIR how they helped people to engage in social activities to reduce the risk of social isolation and promote well-being. The PIR read," We take on additional companionship and recreational activities including accompanying clients to bowls, fishing, shopping expeditions and playing board games with them at home." People told us that they welcomed the visits from care staff as they viewed these as a social, as well as a personal care, call.

People's care records and risk assessments were under review and work was in progress to up-date each person's care records. The operations manager told us that the format of these was in the process of change to enable staff to have easier guidance in how to meet people's individual needs. One person told us that staff read their care plans when they first entered the person's home. They said, "There's a white book that they [care staff] write in each morning and evening. They look at it for any comments and refer to these." Another person also told us that staff wrote in their care records before leaving. This showed that people were protected from the risk of unsafe and inappropriate care.

People were listened to if they wished to raise a concern or complaint. One person said, "I would let them [care staff] know if they have done something wrong and I want things the way that I want them." Another person said that they would ring the office-based staff if they wanted to raise a concern or complaint, but added they had no cause to do so. Members of care staff were aware of the provider's complaint procedure and how they would support a person to raise a concern or complaint. This included informing their manager or advising the person to contact management staff with their concerns.

The provider's PIR described their complaints procedure. The PIR read, "We respond in writing, within 7 days to any complaints that we receive and conduct and communicate the results of our complaints investigations within 28 days, in accordance with our Company's complaints policy." The provider told us in the PIR that, following an analysis of emerging trends in the complaints received, remedial actions were taken to improve the quality and safety of people's care. This included, "We have put in place new systems to advise clients when we have advance warning that carers are running late and we have impressed upon our carers the importance of informing their supervisor when they are delayed so that we can better manage

onward communication with our clients." Staff newsletters confirmed that these actions were taken to remind staff of their roles and responsibilities in improving their communication at all levels.

Good

Is the service well-led?

Our findings

There was a registered manager in place when we visited and they were supported by a team of management and care staff. We received positive comments from all grades of staff about the registered manager's leadership style. Words used to describe their style included "listening", "supportive" and "approachable". A local authority contracts monitoring officer told us that the registered manager co-operated with their team when concerns had been raised. This co-operation included "detailed" investigations and reporting back to either them or an appropriate health or social care practitioner with their investigation findings. The local authority contracts monitoring officer added that they had received "relatively few complaints" about the standard and quality of the care people received from the registered provider.

We found that the provider operated an open culture in the management of the service. The provider's PIR advised us about the systems in place to obtain people's views and ensure that there were in receipt of safe and quality care. The PIR read, "Every year we conduct an extensive client satisfaction survey the results of which are benchmarked against previous year's results. Management reviews and reports upon the results instigating improvement plans where necessary." We saw that the PIR was accurate: the results of the collated survey for 2015 were analysed and compared with the results of the survey carried out during 2014. Actions were taken to address the less than positive comments. This included, for example, ensuring staff were arriving at people's homes at the time they should. Another action was to improve the way teams of staff worked to provide people with a continuity of responsive care.

In addition to this quality assurance system, members of care staffs' work performance was monitored and reviewed. Information contained in the PIR told us that this included 'spot checks' when, "We operate a system of planned and unplanned supervision visits…In addition supervisors carry out unplanned supervision visits arriving at a pre-assigned care visit early to ensure the care arrives on time and then to monitor their work during the visit itself." People were also asked for their views during 'spot check' visits. The field manager told us that they asked people how they were and if they had any concerns or comments. One relative confirmed that they were asked how their family member was being looked after during such 'spot checks'. No changes were needed as the care was meeting their family member's assessed needs.

To continue with how the provider operated an open culture in the management of the service, staff meetings were held. One member of care staff said that these were "casual and informative". Another member of staff said, "Everybody gets a say. Anything we are worried about. We are always allowed to say what we want." This included also making suggestions to improve the quality of people's care. Minutes of staff meetings showed that the management team collectively reviewed the standard of individual members of staff's work performance and their suitability to do their job.

Members of staff were aware of the provider's whistle-blowing policy and knew what they would do if they needed to use it. All of the staff members advised us that they would have no reservation in in reporting any one of their colleagues, should they have concerns about their work or behaviour. This showed that the provider operated a culture which enabled staff to openly report concerns and protect people from the risk

of harm.

The registered manager sent their PIR in when we requested it which showed that they were aware of their legal responsibilities as a registered person. The information detailed in the PIR showed that there was a quality assurance programme in place which aimed to continually improve the standard and quality of people's care. This included, for example, reducing people's isolation with an increase in opportunities to engage in social activities. The PIR read, "We are going to introduce regular client recreation days and social events where we will bring clients (particularly those who are less mobile or isolated) together for entertainment activities, refreshments and open forum discussions during which service users and their representatives will be invited to talk openly about the services we provide and any concerns they may have."

Members of staff were provided with opportunities to develop their career. Both the field manager and operations manager described how they had progressed from being a carer to become part of the management team The provider told us in their PIR that staff development programmes were in place which included those for managers. The PIR read, "managers within the company have attained their NVQ [a nationally recognised training award scheme] Level V Diplomas in Management and Leadership in Health and Social Care and a third is due to complete her Level V diploma in the coming months. This means that including [name of registered manager], our Company will shortly have 4 managers qualified to CQC [Care Quality Commission] standards to become Registered Managers, which is exceptional for a single branch operation." Other details contained in the PIR informed us that, during 2015, provider's training programme "received a Highly Commended Award at the Norfolk Care Awards for Delivering Excellence in Training and Development." This meant that the management of staff ensured that that they were kept up-to-date to ensure people were in receipt of a well-managed service.

The registered manager told us how they aimed to maintain a stable work force and attract interest from prospective staff. They said, "It is a bit early to say [how successful] it is, but we have invested significantly in our work force to pay dividends in the long term." The incentive schemes included a review and implementation of an increase in staff pay.