Stockwellcare Support Services Ltd

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Inspection report

215 Amesbury Avenue
London
SW2 3BJ

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02 December 2016

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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

This inspection took place on 30 November and 2 December 2016 and was announced.

Stockwellcare Support Services is a domiciliary care agency delivering care and support to people in the London Boroughs of Lambeth and Wandsworth. At the time of the inspection the service was providing support to 34 people.

The service had a registered manager at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were trained to safeguard people and knew what actions to take to keep people safe. People's risk of avoidable harm were reduced because they were assessed and plans were made to mitigate them. Staff were suitable and appropriately vetted. People were supported to receive their medicines as prescribed and staff practices minimised the risk of infection.

People were supported by knowledgeable and skilled staff who were supervised and appraised by the manager. People gave their consent to the care they received and were supported people in line with legislation. People were supported to maintain their health and to access healthcare services. People were supported to eat and drink enough.

Staff delivering care and support were caring and kind. People's privacy and confidentiality were protected and they were treated respectfully by staff.

People received care that was personalised to their needs. Assessments identified people's needs and care plans guided staff as to how people's individual needs should be met. People understood the provider's complaints procedure. The provider gathered and acted upon feedback from people and their relatives.

The service had a registered manager who staff felt was approachable. There were robust quality auditing processes in place and the provider liaised with healthcare services, local authorities and other provider agencies to improve its delivery of care and support.

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

People were safe. Staff understood how to protect people from abuse.

People's risks were assessed and plans in place to reduce them.

Staff were recruited using safe and robust procedures.

People received the support they required to take their medicines safely.

People were protected from infection.

Is the service effective?

Good

The service was effective. Staff received a thorough induction and on-going training.

Staff were supervised and appraised by the manager.

People were treated in accordance with the principles of the Mental Capacity Act 2005.

People were supported to stay healthy by accessing healthcare services.

Is the service caring?

Good

The service was caring. People said staff were kind.

Staff treated people with dignity and respect.

People's confidentiality was protected.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and care plans were in place to meet them.

People were supported to have reassessments when their needs changed.

People knew how to complain and the provider acted on people's feedback.

Is the service well-led?

Good

The service was well led. The service had a registered manager.

Staff felt supported by the manager and office based team.

The service used a number of auditing and checking systems to measure and improve quality.

The provider worked cooperatively with other agencies when supporting people.

Stockwellcare Support Services

Detailed findings

Background to this inspection

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

This announced inspection took place on 30 November and 2 December 2016 and was undertaken by one inspector. The provider was given 48 hours' advance notice because the location provides a domiciliary care service and we needed to ensure the registered manager and staff were available. This meant the provider and staff knew we would be visiting the agency's office before we arrived.

Prior to the inspection we reviewed the information we held about Stockwellcare and Support Services including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We used this information in the planning of the inspection.

During the inspection we spoke with six people, three relatives, the operations director and the registered manager. We also spoke with four staff. We reviewed 11 people's care records, risk assessments and medicines administration records. We looked at documents relating to staff and management. We reviewed nine staff files which included pre-employment checks, training records and supervision notes. We read the provider's quality assurance information and audits. We looked at complaints and compliments from people and their relatives.

Following the inspection we contacted five health and social care professionals to gather their views about the service people were receiving.

Good

Is the service safe?

Our findings

The risk of people being abused was reduced because staff received training in safeguarding and knew what actions they should take to protect people. Staff were able to tell us about different types of abuse and what they would do if they suspected people were being abused or at risk of abuse. One member of staff told us, "If I felt someone was being abused even if it was a family member or a neighbour I would be straight on the phone to my manager who would tell social services and the police." Another member of staff said, "I would immediately tell the manager." This meant people were protected by the provider's safeguarding procedures and staff familiarity with them.

Staff understood the provider's whistleblowing policy. Whistleblowing is a term used when staff alert outside agencies when they are concerned about the provider's care and support practice. A member of staff told us, "You have to report abuse and the reporting needs to go up the chain. If managers didn't report what I had told them about abuse to social workers or CQC then I would."

People were protected from the risk of avoidable harm. Managers assessed people's risks as part of their initial needs assessments before they received a service and updated them as people's needs changed. People, relatives, staff and health and social care professionals reviewed people's risk assessments and risk management plans during care review meetings.

People were protected from the risk of pressure ulcers. People at risk of pressure ulcers were assessed by healthcare professionals and staff had guidance. Care records directed staff to support people's positioning, encourage optimal hydration and inform healthcare professionals. Staff had guidance about identifying areas where skin integrity was threatened. For example, where appropriate care records noted that black people's skin may not always redden but darken in pressure sore areas. This meant staff knew how to detect pressure ulcers and had direction on the actions to take to protect people's skin.

People who were unsteady on their feet were supported with falls prevention strategies. These included assessments of falls risks and included factors such as people's abilities and environment. A member of staff told us, "I always make sure there are no trip hazards in people's homes. For example, no up-edged rugs or cable leads." Another member of staff said, "It's very important to make sure that all bathroom surfaces are dry after giving personal care. It's as easy to lose balance and fall if weight is put on the rim of a bath or sink as it is to slip on a wet floor."

People told us they felt staff kept their homes safe. The means by which staff gained access to people's homes was stated in care records. Some people let staff into their homes. At other people's homes it was relatives who opened the door. When attending some care visits staff gained access to people's homes using a safe key which required the use of a code which was kept confidential.

The provider took steps to reduce the risk of missed and late calls. The service provided staff with mobile phones to ensure that staff could notify the office if they were running late, enabling office staff to inform people of changes. The provider in collaboration with the local authority introduced electronic call

monitoring systems in October 2016. These touch in and touch out systems recorded the arrival and departure of staff from people's homes and were used in 16 people's homes initially with a plan to use them at each person's home. We found one incident of a late care visit. However, the provider responded appropriately and electronic call monitoring was installed to prevent a recurrence.

The provider had enough staff available to support people safely. People and staff were given rotas and staff told us they had sufficient time allowed for travel between care visits to ensure they were not late. Where people required two staff to support them to transfer this was recorded in people's assessments, care plans and rotas.

People were supported by staff recruited using safe procedures. The provider ensured that staff were suitable to work with people by interviewing applicants, confirming staff identities, reviewing details against criminal records and barring lists and taking up two references for successful candidates.

People were supported to take their medicines safely. The support people required to take their medicines safely were stated in care records. For example, some people required reminding whilst other people required staff to hand them their medicines and a glass of water. Staff signed people's Medicines Administration Record (MAR) sheets to confirm they had observed medicines being taken. Staff understood the actions they needed to take in the event of a medicines error. One member of staff told us, "I'd call the office to tell the care coordinator, I'd write it on the MAR sheet and communication book." We found that when an error had occurred in one person's medicines collection procedures the provider put in measures to prevent its recurrence. Managers audited MAR charts and observed staff medicines practices during spot checks at people's homes.

People were protected by the infection control practices used by care staff. Staff used personal protective equipment (PPE) when supporting people. "When I support people with personal care I wear gloves and put them in the bin after using them." Another member of staff said, "I wash my hands before and after preparing food." This meant people were protected from the risk of cross contamination.

Good

Is the service effective?

Our findings

People told us the staff supporting them possessed the skills and knowledge to do so effectively. One person told us, "My [care staff] is very good. They've plenty of experience in care. They talk to me and the nurse who visits confidently and I have seen the notes [staff] write." A relative told us, "The regulars are well on top of their game. Meds, hoist, changing, they are spot on. No problems."

Upon joining the service staff proceeded through an induction programme. Subjects covered during staff induction included medicines, health and safety, moving and handling, first aid, infection control and food hygiene. One member of staff told us, "I had a two week induction. I did shadowing. I learned a lot from shadowing. I learn more from practice than theory." Shadowing entailed accompanying an experienced member of staff observing and assisting with care and support and reading peoples care records. This meant people were supported by staff familiar with their needs and preferences and capable of meeting them in line with their care plans.

Staff supporting people were supported by their managers. Staff were supervised by managers through spot checks at people's homes and one to one supervision meetings. Minutes were taken at supervision meetings and retained by both parties. One staff member's supervision meeting recorded discussion about the significantly changed healthcare needs of a person and the importance of staff informing the office regularly about their condition. In another example we read that discussion had taken place about a person's diminished appetite. Whilst a further supervision record showed that the manager and staff discussed a person refusing medicines. This meant staff were supported to reflect upon and improve their delivery of care.

People received support from staff whose performance was monitored and appraised. Staff received annual appraisals from the manager. Appraisals addressed the personal development of staff. For example, one staff member's appraisal recorded the manager's view that the staff member had reached a level of experience at which it was appropriate for new staff to shadow them during induction. We found appraisals addressed performance issues including punctuality and personal development issues including training.

People made choices about how they received care and support. For example, people, their relatives, social workers and the provider agreed the times and duration of care visits dependent on people's agreed identified needs.

People were treated in accordance with the Mental Capacity Act 2005 (MCA). The manager and staff had a clear understanding of the MCA and the Deprivation of Liberty Safeguards (DoLS). People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)."

People were supported to eat and drink enough. Staff supported people's nutritional needs in line with their assessed needs. One member of staff told us, "I see one person who needs their food cut small and another

who needs to be fed. You do what it says in the care plan but you do it respectfully and talking to them." Another member of staff said, "I cook whatever the person asks me to." The manager knew what steps to take if they were concerned about that a person may be at risk of choking. For example, contact their GP and make a referral to speech and language therapy for a swallow safety assessment to be undertaken.

People received the support they required to remain healthy. Staff supported people, in line with their care plans, to meet with healthcare professionals. Staff recorded the outcomes of appointments in care records. One member of staff told us, "I take people to some appointments and I am there to let in [healthcare professionals] when they do home visits." Another member of staff said, "There are tasks that nurses do that we don't like injections and [specialist feeding] but they are always sharing tips and knowledge with us." This meant people accessed healthcare services in a timely manner.

Good

Is the service caring?

Our findings

People told us they shared positive relationships with staff. One person told us, "My [care staff] is a gem. [They] work hard and don't have a lot of time. But you wouldn't know it. I don't feel rushed and [they're] always upbeat." Another person said, "The regular staff are lovely, just lovely. I can't say better than that."

People were supported to make decisions about how they received their care each day. A member of staff told us, "People make choices about their personal care each day. They might want a bath, bed bath, shower or strip wash." Another member of staff told us, "I just ask people things like, 'What would you like to do now?' Or 'What would you like to eat or drink?' and they decide." A third member of staff said, "I work at [the person's] pace. People aren't the same every day. Sometimes their mood is up and sometimes it's a bit down. Some days people are a bit stiff or sore. So you talk and reassure them and agree together how fast or slow we go."

Staff supported people to maintain their independence. Staff supported people in line with care plans which provided guidance about people's capabilities. For example, one person was able to drink independently using a straw. Records detailed what aspects of their personal care people were able to meet without assistance. Where relatives met people's needs this was stated in care records to ensure people, relatives and staff were clear about the plan to meet people's needs.

People and their relatives told us that staff treated people with dignity and respect. One person told us, "Yes, they are always caring." Another person told us, "My regular [care staff] is ever so friendly. Always thoughtful." Another person told us, "I have not met a [care staff] who wasn't nice." One relative told us, "The staff I have encountered have been conscientious in how they have carried out their duties and all seem suited to the caring profession."

People had their dignity protected. People said they felt comfortable with the way staff provided their personal care. Staff discussed people's preferences for how their personal hygiene needs were met. People were encouraged to wash the areas of their bodies they could reach. People told us that staff showed sensitivity about people's feelings about being undressed. One person told us that it was important to them that staff maintained a casual conversation about "other things" when being supported with personal care. Whilst another person told us that staff ensured they were never completely naked by using a towel or dressing gown.

Staff ensured that people's privacy was respected. Staff understood the provider's confidentiality policy. Care records were kept securely in people's homes. This meant that visitors were not able to see private and confidential medical information.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs. Staff provided care and support in line with care plans developed with people, relatives and health and social care professionals. People told us they understood their care plans and were involved in their needs assessments. People were supported with reviews and reassessments when their needs changed. For example, one person was supported to have a care review when their mobility needs increased.

People's care records were person centred and provided staff with information about people's preferences. Care records included people's cultural and dietary preferences and details of how these should be supported. For example, one person received their care and support earlier each Friday to enable them to attend a mosque. In another example, a person was supported to wear more formal clothing when supported with personal care on Sundays prior to going to church.

Staff had guidance in care records on how to effectively deliver care and support. Care records contained up to date information about people's needs including their health, mobility and risks. The manager and care coordinators regularly reviewed care records to ensure they remained accurate. Care records were updated to include the outcomes of health appointments and any actions required. For example, when requested by a healthcare professional staff supported people to keep a record of their weight.

Where it was stipulated in care packages staff supported people to participate in activities. Records showed people were supported to go to swimming sessions and with shopping and banking.

People shared their views about how they experienced care and support. The provider carried out an annual satisfaction survey. The provider's most recent survey revealed that 96% of respondents were satisfied with the support they received. The provider took action in response to areas of improvement indicated by people during the survey. For example, as a result of a number of people suggesting that staff should wear a uniform the provider responded by introducing a burgundy uniform featuring the providers name for all care staff. This meant the provider sought the views of people and responded to them to improve the service.

People knew how to complain. We read the provider's complaints records and found complaints were forwarded to the manager who acknowledged them, investigated them and provided a written response within the timeframe stipulated in the provider's complaints policy.

Good

Is the service well-led?

Our findings

People, relatives and staff expressed confidence in the managers of the service. One person told us, "They seem like competent managers. I find them efficient and professional." A relative told us, "I haven't met any of the office staff but they are always polite and helpful when I phone." A member of staff told us, "They [the registered manager and office based team] are very supportive. I never [worked] in care before but I am happy and at peace with myself because they have supported me to be a confident carer."

Staff we spoke with understood their roles and those of the office team which included the registered manager, director of operations and two care co-ordinators. The vision and values of the service were understood by the staff we spoke with and were discussed in team meetings.

The manager promoted effective communication throughout the service. All care staff were issued with mobile phones to enable them to maintain contact with care coordinators and ensure a timely response to changes. Staff attended team meetings. Minutes of one meeting noted the manager emphasizing the importance of early notification if a care visit cannot be attended. Records from another meeting showed that the manager and team discussed no response procedures and the actions staff should take if people did not answer the door to staff as planned. These actions included notifying the office who would then phone the person, a relative or neighbours, where this had been previously agreed with people. This meant people were supported by staff who were continually advised about good practice.

The provider operated quality monitoring procedures. Office staff made quarterly monitoring phone calls to people to receive people's evaluations of the quality of care they were receiving. Care co-ordinators and the operations manager conducted regular spot checks. These unannounced observations of staff took place in people's homes with their foreknowledge and consent. Records of spot checks noted the punctuality of staff, their use of personal protective equipment and moving and handling techniques. One record from a spot check included the observation, "Encouraged [person's name] to be independent with [personal care tasks]." Where spot checks identified staff performance issues records showed these were addressed in one to one supervision sessions. One member of staff told us, "Being watched while you are doing anything can be a bit stressful but when a [person] praises you in front of your manager it feels great." Another member of staff said, "The spot checks are good. They help you stay on the straight road. They make sure you're doing your job right."

The registered manager regularly sought advice from health and social care professionals. The service collaborated with healthcare professionals to meet people's needs and made timely referrals to specialists for their input. For example, staff worked with district nurses, physiotherapists and social workers to plan and deliver care and support. The service attended a local provider's forum where good practices in service delivery were discussed.