Ms Elizabeth Speight

All Seasons

Inspection report

Suite 2, Premier House
New Hold Industrial Estate, Garforth
Leeds
West Yorkshire
LS25 2LD

Tel: 01132874221

Date of inspection visit:
11 December 2017
14 December 2017
15 December 2017
21 December 2017

Date of publication:
22 February 2018

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?	Requires Improvement

Summary of findings

Overall summary

All Seasons was registered with CQC in December 2016 and this was the first inspection of the service. This inspection took place on 11 and 14 December 2017 and was announced.

All Seasons is a small domiciliary care service that provides personal care to people in their own homes within the Leeds area. The service provides care for people living with dementia, older people, people who may have an eating disorder, physical disabilities and people over the age of 65 with a sensory impairment. At the time of our inspection there were seven people using this service.

The service had a manager who was in the process of applying to the CQC for registration. 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 using the service told us they felt safe. Care workers followed the provider's policy to report any potential abuse or harm towards others.

Risk assessments were used to protect people from potential and avoidable risks. We saw these were updated when needs changed or new risks were identified. Accidents and incidents were reported, with actions taken to prevent reoccurrences.

Medicines were managed safely and people told us they received these on time. Medication Administration Records (MARs) were signed by care workers and 'As required' protocols were followed.

Staff were recruited with relevant documented checks to ensure it was safe for them to work with vulnerable adults. Staffing levels were sufficient. Planned rotas showed that people had the same care workers to support their visits when this was possible.

People using the service told us care workers were well trained and we saw evidence that care workers had participated in regular training to ensure they could meet people's needs. Induction programmes were provided for new staff which followed the Care Certificate, which is a set of standards that social care and health workers follow in their daily working life as recommended by Skills for Care, a national provider of accreditation in training.

We found care workers were supported by management with supervisions, competency and spot checks. However, these did not follow the provider's policy. The policy was amended on the day of inspection to reflect this.

The provider followed The Mental Capacity Act 2005 MCA legislation with capacity assessments documented

and best interest meetings recorded when required. We found consent was obtained from people verbally on a day to day basis and formally at review meetings.

People were supported with their nutritional and health needs. Care plans identified people's preferences for dietary requirements. Care files contained referrals to relevant health professionals and documentation of actions taken to support people's needs.

Care workers were aware of people's need for privacy and respected their dignity upon visits. People and care workers had good relationships and this was reflected with positive comments from people using the service.

People using the service told us the care workers provided explanations of what they were doing during their visits and asked their permission to carry out support work.

We found people were supported to remain independent and when additional support was required the provider would action relevant referrals to support individuals.

Care files were person centred focusing on peoples preferences, which included likes and dislikes. People told us they were always offered choices and made decisions about what to wear or to eat.

Initial assessments were completed and care files contained people's information about the care they needed. Regular reviews took place with people using the service and their relatives.

The provider managed complaints effectively with an immediate response, investigations and written outcomes. We also found several compliments which had been received which were very positive about the care being provided.

Care workers told us they felt supported by the management and described the working relationship as a 'family'.

The manager had not registered with the CQC although they had been in the post for 12 months. The manager had taken steps to apply at the time of our inspection.

Audits were completed on a weekly or monthly basis to ensure the quality of the service was being monitored. Annual surveys were completed by people who used the service and care workers with positive feedback received.

As the service was small, communications were often by text message, although staff meetings sometimes took place if needed.

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 we spoke with told us they felt safe. Care workers received training in how to protect people from abuse and what to do if they suspected abuse was taking place.

Medicines were managed safely and people told us they received these as prescribed.

Risk assessments were in place for people who needed them and were specific to people's needs and their home environment.

Care worker numbers were sufficient to meet people's needs. The files of the most recently recruited staff were kept in line with the provider's policy.

Is the service effective?

Good

The service was effective.

Training and induction programmes were provided to give care workers the skills and knowledge to meet people's needs.

The provider understood how to support people in line with the Mental Capacity Act 2005 and used best interest decisions when required.

There were systems in place to support staff in their roles.

People were supported with their nutritional needs and supported to access input from health professionals when required.

Is the service caring?

Good

The service was caring.

People were treated with care, dignity and respect from care workers. People had positive relationships with care workers.

Daily notes were detailed and reflected people's needs as written

in their care plans.

People were supported to remain independent and when additional support was required the provider would action relevant referrals to support individuals.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and appropriate care plans were in place and regularly reviewed.

Care files were person centred and detailed people's preferences, likes and dislikes.

The provider had a system in place to manage and respond to complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider was not meeting their registration requirements in that a manager had been in post for 12 months and had not registered with the Commission in a timely manner.

People spoke positively about the management of the service and felt supported.

People were satisfied with the service they received and their views were sought.

The service was monitored with audits and actions were taken to maintain or improve the service.

All Seasons

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 checked whether the provider was 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.

We gave the service four days notice of the inspection visit because it is small and the manager is often out of the office and we needed to be sure that someone would be in.

Inspection site visit activity started on 11 December 2017 and ended on 21 December 2017. We looked at a range of records including five staff files relating to recruitment, supervision, appraisals and training. We also looked at three people's care records which included care planning documentation, risk assessments and daily records. We viewed records relating to the management of the service, surveys, audits and a wide variety of policies and procedures. We visited the office location on 11 and 14 December to see the manager and office staff; and review care records, policies and procedures.

Before this inspection we reviewed information we held about the service. This included statutory notifications received from the provider. Statutory notifications are notifications of certain events and incidents that the provider has to inform the CQC of by law. We used this information to help plan the inspection. Before the inspection, the provider completed a Provider Information Return (PIR) and we reviewed this information. 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 also contacted the local authority, local safeguarding team, and Healthwatch to obtain information about their views of the service.

During the inspection we spoke with two people who used the service, two relatives, the manager, administrative staff and three care workers.

Good

Is the service safe?

Our findings

People using the service told us they felt safe, with comments including, "I like them coming to me, I trust them and I love them all" and "I couldn't have better carers. I feel safe, very much so."

Safeguarding and whistleblowing policies were in place and staff had a clear understanding of the procedures to follow should they suspect any form of abuse or harm. Care workers demonstrated a clear knowledge of the different forms of abuse. One care worker told us, "If I identify someone who is not safe or at risk I would speak to the manager or speak to the safeguarding team myself." Another care worker said, "I would try and get as much information from the customer and pass it on, then they would do an investigation."

We saw three safeguarding concerns had been raised over the last 12 months and actions had been taken to ensure people were kept safe. For example, care workers found a boiler which was unsafe in a person's home. They informed the family, safeguarding, fire service and the local gas board. The provider offered emergency services but the person wished to remain home. The boiler was turned off and heaters bought in to ensure the person was warm enough until a new boiler was installed.

Risk assessments were carried out when required or if people's needs changed. Some of these included mobility, medication, falls and safety. For example, some people had a key box outside of their house so care workers could safely enter the home if a person had difficulties with mobility. Health and safety checks were carried out in people's homes to ensure their safety. For example, one person required grab rails to support their mobility around the home and wore an alarm pendant at all times in case of a fall when no one was present. One care worker told us, "We look to see if they need any aids or equipment. [Staff member's name] goes in to risk assess and make sure it's safe. We get trained to use the equipment to learn how to use it. We can't do it if we are not trained as we need to be shown."

The provider also took action to reduce and mitigate risks as much as possible. For example, a person using the service had been assessed due to their unsteadiness when walking. The person was at risk of potential falls due to rushing to the bathroom during the night. The provider accessed a commode, to offer the choice of using this during the night to avoid future falls.

Accidents and incidents were managed effectively. We found two falls had occurred in December 2017. The manager discussed these falls with the inspector prior to sending a notification to the CQC. We found the manager had taken action, involved the falls team and met with the person and their relatives to discuss rehabilitation options to support the individual moving forward. Body maps were completed to show any injuries that may have occurred from any falls.

Staffing levels were sufficient to meet people's needs. We found there was consistency on the rotas which meant people using the service had regular care workers that they knew. One relative told us their relative had the same carer worker because they had memory problems and familiar staff made it easier for them to remember.

People using the service had access to support during the night if there was an emergency or if care was required. This was offered via an 'on call' service outside of normal office working hours.

We looked at staff recruitment records which showed the checks that were undertaken before staff began work. Checks included application forms, interview notes, confirmation of identity, two references and a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff have a criminal record or are barred from working with children or adults at risk and help employers make safer recruitment decisions. We looked at five staff files and found one which did not include two references or formal interview notes. We discussed this with the manager who told us the person had worked with the provider since 2014 and that all new staff now have a check list to follow which includes all the relevant information. We found that all other files included the relevant information.

Medicines were managed safely and people told us they received them at the correct times. One relative told us, "Yes [Name] always get their medicines. If I need to change I will ring them up or they ring me to tell me."

We looked at (MARs) which document the medicines people had been prescribed and recorded when medications were administered to them. We found medicines had been administered with signatures and correct codes were used when medicines were not administered. Audits were completed weekly and actions taken. For example, one MAR had no details of the doctor and staff were all messaged to inform them of the importance of recording full information. We found on two MARs erasing fluid was used and this was not picked up on the audit. We spoke to the manager about this who immediately informed staff that this was not good practice and that it should no longer be used.

We found 'As required' medicines (such as medicines given for pain relief) were provided and protocols were in place within care files for care staff to follow. These included what the medication was to be used for, when the person may need this medication and information about the maximum dosages to be given. Body maps were also used to direct care workers on where topical medicines, such as creams and ointments should be administered.

The provider had an infection control policy which was followed by the care workers. We saw care workers had documented in people's daily notes when protective items were worn when delivering personal care or preparing food for people in their homes.

Good

Is the service effective?

Our findings

People using the service, their relatives and care workers told us they had received effective training to perform their job roles. One person using the service told us, "Yes they (staff) are very particular and so thorough."

Training was kept up to date and the manager used a matrix to monitor this. We found most care workers had completed their training and if not, they had been booked on a course to complete it. Training was completed at a local care school and on an e learning (online) system which included first aid, food safety, health and safety, safeguarding, moving and handling, infection control and medication management. New care workers participated in a three day course of all training and following this annual updates were completed.

One care worker expressed their views on training in the annual survey, stating they enjoyed the, 'Refresher courses as things are always changing in care and it helps you to perform your job and keeps you updated when you go on them yearly.'

New care workers completed an induction programme including shadowing of established staff, competency tests and supervisions. New staff without experience completed the Care Certificate which is a set of standards that social care and health workers follow as recommended by Skills for Care, a national provider of accreditation in training. The manager told us there was no limit on how long a care worker would shadow others, but that this was assessed by their competency to do the work effectively.

A supervision policy was in place although this was not always followed. The policy stated four formal supervisions should be carried out within a year however; this was not the case in four out of the five staff files we looked at. People were provided with supervisions but in most cases this was one or two within the year, not four as stated in the provider's policy. We found this to be of low impact as staff had regular competency and spot checks throughout the year which meant care workers were being assessed and their performance monitored. Care workers also told us they felt supported and could access support at any time. We saw all staff had received an annual appraisal if they had been working for over 12 months.

We discussed this with the manager who then changed the policy to include spot checks and competencies as part of their formal supervision of staff.

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.

Where people had been assessed as having a lack of capacity to make some important decisions, care plans included capacity assessments and best interest decision meetings which meant discussions were held

about a person's care. For example, a person using the service lacked capacity to take their own medication; a best interest meeting was held with health professionals and family to discuss and it was agreed for the provider to administer medicines to prevent the person from missing their medicines due to memory loss.

Staff were able to demonstrate their understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). One care worker told us, "Always assume they can make decisions, bearing in mind it may fluctuate, for example if a person has a urine infection."

Care workers told us they gained consent from people by informing them of the care they wanted to provide and asking people. One care worker said, "I ask people and they sign the care plan." Another care worker told us, "I ask them. If I'm doing personal care I will ask them if they are ok and when are you ready. I will tell them what I'm doing and ask if it's ok to carry on."

People using the service were supported with their dietary and fluid needs. One care worker said, "We prepare meals and some people do it themselves if they can. We check that the food is hot but not too hot to burn. I will make a cup of tea and leave them with some other drinks." People using the service told us they were provided with enough drinks to have when care workers were not present. People told us they were offered a choice of refreshments and food when care workers visited.

Health professionals were regularly contacted if there was a need. For example, one relative told us the provider had contacted the district nurses when their relative had an abscess on their knee following a fall. We saw contact details of health professionals in peoples care files and details of any changes needed to their care within the notes following professional visits.

Good

Is the service caring?

Our findings

People told us they felt well cared for and had positive relationships with their care workers. One person said, "I couldn't have better carers. They are on time, do what they have to do and if I need anything they do it. I like them all." A relative told us, "They are really brilliant. Lovely and nice. No complaints. They are good for my dad."

Care workers were respectful of peoples need for privacy and dignity. One person commented, "They are always respectful" and another person said, "I wash the front of me and they do my back. They always say excuse me and they are kind to me." Care workers told us about the ways in which they upheld people's privacy and dignity. One care worker said, "If in the bathroom make sure the door is closed, cover with a towel and make sure no one comes in."

The manager told us they were not currently supporting anyone with specific cultural, religious or diverse needs but explained that should any person require such support they would accommodate this.

People told us they were informed about their care and in daily interactions care workers explained what they did. For example, one person told us, "They are all polite and respectful. They ask me and tell me when they are doing things." Relatives also told us that they were regularly contacted if there had been any changes to a person's care.

Daily notes were detailed with care workers documenting what had happened at each visit and these were consistent with the care provision as detailed in their written care plans. This included activities such as bathing or showering, nutritional and diet information, health professional visits and medication administration. For example, '[Name] was still in bed asleep on arrival, washed hands, put PPE (Personal Protective Equipment) on, got bathroom ready, put clothes to warm and woke [Name] gently. [Name] got out of bed unaided and came into bathroom using zimmer frame. [Name] sat on the toilet p/u, assisted to undress and gave full body wash, dried, applied Diprobase cream to back, Connotrane cream to groin area and under bust. Dressed, brushed hair, teeth, glasses and pendant put on. Meds given from dosette box [Name] refused paracetamol all taken with water and recorded. Made warm drinks and filled flask with hot water. [Name] wanted scrambled egg with a slice of bread and butter.'

People using the service were encouraged to remain independent. One person told us, "I can look after myself but they are there if I need them. I had a fall and could barely walk but now I can walk with my zimmer. I can do more for myself now, so my hours were reduced as I can now put myself to bed when I want." The manager also provided an example of supporting a person into a rehabilitation facility to help regain their mobility skills. They had also made several referrals to other agencies such as the falls team and physiotherapists to ensure people remained independent for as long as possible. We saw evidence of this in peoples' care files.

No person using the service had an advocate, however, we found advocacy information within people's care files should they wish to contact services to support them. An advocate is a person who can support others

to express their views, if they are unable to do this for themselves.

Staff respected the need for confidentiality. People's personal information in care files was stored securely in a locked cupboard in the office and within people's homes.

Good

Is the service responsive?

Our findings

Care files were person centred with people's like and dislikes included so care workers knew people's individual preferences. For example, one care file stated, 'Wake [Name] gently and open bedroom curtains and blinds, let [Name] know you are going to prepare the bathroom and ask [Name] if she would like a shower, hair wash or a strip wash then prepare as necessary.' Another care file stated, '[Name] likes small portions of food and dislikes strong tea.' One care worker stated, "It's about what a person likes or dislikes and what they choose to do. Even if you don't agree, it's up to them."

Care files also included historic information which meant care workers could talk with people about their life and form relationships. Information was provided about where people were born, their family life, previous employment, interests and hobbies.

People told us they were offered a choice and this was reflected in peoples care files for example, 'Make [Name] a choice of breakfast and serve it at the dining room table. Make sure the knife and fork with the bone handles are used as [Name] can't grip the metal handled ones.' One person told us, "They make me a cup of tea and offer me a choice if I want something else." Another person said "We go to the bathroom and they bring things from my wardrobe and ask me if I want to wear it or bring something else."

Initial assessments were in place to ensure the provider could meet people's needs, some of which included people's mobility levels, assessment of risks, medication needs, mental and physical health.

We saw regular reviews of care files took place when a person's needs changed and annual reviews with people using the service and their relatives were conducted. People using the service told us they knew of their care plans and they were available in their homes should they wish to read them. Relatives also told us that they were informed of any changes and were regularly contacted by the care workers.

People we spoke with did not comment on any social activity support they received. The manager told us that activities would only be provided if this was part of people's agreed care packages and if documented in their care plan. At the time of our inspection no person received support to meet their social needs.

The provider had received one complaint over a 12 month period and followed the correct procedure set out in their policy. This was responded to within 24 hours, concerns were investigated, meetings held and a written letter with the outcomes and an apology was provided to the complainant.

The provider had also received five compliments in the past 12 months. One person using the service had commented, '[Care worker] is very helpful and couldn't manage without her.'

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the manager had not registered with the CQC to become a registered manager and had been in this post for a period of 12 months. The manager told us they plan to apply for this and had already taken steps to download the forms required. This is a requirement of the provider's registration that is not being met. We discussed this with the manager who advised that they would ensure a correct application was promptly submitted.

Care workers told us they felt supported by management and gave positive comments which included, "I think we are a great team and if I had to pick, I would pick us. I gel with the manager well. We are like a family, real good interaction and have everyone's best interest at heart. We are all passionate and want to do well." Another person told us, "Yes, I'm well supported. [The management] help if you have any difficulties and give advice. I can say anything to them and they respect what you are saying. It's a friendly company; it's more like a family."

We found audits were completed regularly with weekly medications being checked, time sheets and invoices along with monthly daily note audits. We did find on some medication audits that the use of erasing fluid on MAR's had not been identified and following discussions with the manager on the day of inspection the care workers were notified of ceasing this practice immediately. All other audits were completed and actions taken to address any identified issues when required. These included group text messages sent to care workers if incorrect information had been identified and formal conversations with care workers when required.

Annual surveys were issued to people using the service and care workers. The manager told us there was no overall analysis of this information due to the small size of the service and that they responded to each survey individually with actions taken in response to any concerns or issues raised, should this be the case. The last survey completed by seven people using the service in August 2017 showed positive feedback on all questions apart from one where a person was unsure on the complaints procedure. The manager responded with a written letter detailing the procedure to take should they wish to complain. Comments from the survey included, 'I look forward to when the [Care workers] come' and 'Arrive on time, give nice showers and generally very caring.'

Four care worker surveys were completed in January 2017. Care workers commented that they enjoyed their work and the care they provided.

Staff told us they regularly communicated by group text. All care workers had access to a phone and were part of this group. This was used to update everyone on any care matters, general information and to communicate with each other. The administrator told us, meetings sometimes took place, the last one being a few weeks prior to the inspection. However, their main route of communication was through text message. For example, after speaking to the manager about the use of erasing fluid on MARs a group text was sent to all care workers to instruct them not to do this.