London Borough of Enfield

Carterhatch Domiciliary Care Service

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place over two days, 17 and 18 November 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service. Carterhatch Domiciliary Care service is provided by the London Borough of Enfield. It provides care and support for around 70 people in their own home. The service works with people living with dementia, learning disabilities, and people with autistic spectrum disorder, older people and people with sensory and physical impairment.

The service was last inspected 14 November 2013 and was meeting all the regulations inspected. There was a registered manager in post. A registered manger is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of law; as does the provider. The registered manager was not present during the inspection.

Summary of findings

People were involved in decisions about their care. Where people were unable to have input, best interests meetings and decisions were recorded. Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report it to if people were at risk of harm. Staff had an understanding of the systems in place to protect people who could not make decisions and followed the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

There were individualised care plans written from the point of view of the people that were supported. Care plans were detailed and provided enough information for staff to support people. We saw that care plans were regularly reviewed and updated as changes occurred.

Risk assessments gave staff detailed guidance and ensured that risks were mitigated against in the least restrictive way. Risk assessments were reviewed and updated regularly.

People received a continuity of care. The provider always tried to ensure that the same care workers looked after people. This promoted good working relationships with people who used the service.

There was a system in place to monitor any missed visits. Missed visits were investigated and followed up. The provider had begun to introduce a new electronic monitoring system to monitor visits.

People were encouraged to have input into their care and the service. The provider ran a quarterly service user forum where people were encouraged to discuss issues and say what they did and did not like about the service they received.

People and relatives said that they were treated with dignity and respect. Staff were able to give examples of how they ensured that they promoted dignity. People were encouraged to be as independent as possible.

Staff received regular, effective supervision and appraisals and attended monthly team meetings. Senior staff completed regular monitoring of care staff via monitoring visits.

We found that there was an open culture that encouraged staff and people to discuss issues and ideas, though team meetings and service user forums. Team leaders supported care staff on a daily basis.

Staff had received training on medicines administration and people were supported to take their medicines safely. Medicines were accurately recorded on medicine administration (MAR) sheets.

Audits were carried out across the service on a monthly and quarterly basis that looked at things like, medicines management, health and safety and quality of care. There was a complaints procedure as well as incident and accident reporting. Where areas for improvement were identified, the registered manager used this as an opportunity for change to improve care for people.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

There were sufficient staff to ensure people's needs were met.

People were supported to have their medicines safely.

Risks for people who used the service were identified and comprehensive risk assessments were in place to ensure known risks were mitigated against.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role. People were supported by staff who reviewed their working practices as staff received regular supervision and appraisal.

Staff understood their responsibilities in relation to meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Depravation of Liberty Safeguards (DOLS).

People's food and dietary preferences were noted in their care plans.

Peoples healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

Is the service caring?

Good

The service was caring. People were supported and staff understood people's needs.

People were treated with respect and staff maintained privacy and dignity.

People were supported to make informed decisions about the care they received.

Is the service responsive?

Good

The service was responsive. People's care was person centred and planned in response to their needs.

Staff were knowledgeable about individual support needs, their interests and preferences.

Complaints were responded to in an effective and timely manner.

People were encouraged to have full and active lives and be part of the community.

Is the service well-led?

Good

The service was well led. There was an open and transparent culture where good practice was identified and encouraged.

Complaints were used as a learning opportunity to improve quality of care.

Audits and surveys were carried out to assess the standard of care.

Carterhatch Domiciliary Care Service

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 17 and 18 November 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We looked at 13 care records and risk assessments, seven staff files, 23 people's medicines charts and other paperwork related to the management of the service. We spoke with four people who used the service, nine staff and nine people's relatives.

Good

Is the service safe?

Our findings

People and their relatives told us that they felt safe. One person said, "I'm very pleased with things so far. Yes, I feel safe." Relatives said, "She's safe, absolutely" and "Yes, she's always safe with them [the staff]."

All staff members that we spoke with were able to explain how they would keep people safe and understood how to report it if they felt people were at risk of harm. Staff were able to explain different types of abuse and how to recognise it. One staff member told us, "It is for the protection of vulnerable adults, knowing what abuse is and how to report it." Another staff member said, "It's about providing a service where [people] are taken care of in a way that they are not abused and how to recognise and report it if we see anything." Staff told us and records confirmed that they were trained in safeguarding during their induction.

Staff understood what whistleblowing was and knew how to report concerns if necessary.

We found that individual risk assessments minimised risk in the least restrictive way. Risk assessments were regularly reviewed and changes made when needed. They also showed that, when necessary, the staff had liaised with other health care professionals and relatives when devising the most appropriate risk assessments. For example, we saw that one person had had a fall. Their risk assessment had been updated with guidance on manual handling for staff following input from a physiotherapist. Risk assessments showed how to respond to people if they were anxious or became distressed. People had signed their risk assessments. Where people were unable to sign, family members had signed on their behalf. Risk assessments were tailored to the individual and showed a good understanding of person centred care.

All people's files contained a 'lone working policy'. There was a risk assessment for staff, individualised to each person that they worked with. This identified any risks that staff faced when working alone in people's homes. The service recognised and mitigated risk for staff when working alone.

Staff files noted recent criminal records checks and their application form. However, staff identification, references and eligibility to work were held by London Borough of Enfield human resources (HR) department. During the inspection we requested to see this documentation but it was unavailable due to data protection issues. Following the inspection we spoke with the service manager who had checked with HR and seen the relevant documentation. Staff records included proof of identification, eligibility to work in the UK and two references. However, there was no identification for three staff. This was because they were employed prior to the Immigration, Asylum and Nationality Act (2006) coming into force. The immigration, Asylum and Nationality Act (2006) sets out responsibilities for employers to ensure that people have identification and the right to work in the UK. The service manager told us that she had immediately requested that the three staff in question provide identification and proof of eligibility to work in the UK.

Staff told us, and we saw, that people often had the same care workers visiting them, which enabled people to experience continuity of care. One person told us, "I do get regular carers come to me, I don't want any changes. If there are any changes the company is always very responsive and phones me." Relatives told us, "The same carers come every week"; "We always have the same staff. We get to know them."

Medicines were administered in people's homes and staff returned the medicine administration record (MAR) sheets to the office monthly. We looked at 23 MAR sheets from October and November 2015. There were monthly audits of all MAR sheets completed by team leaders. The team leader showed us how auditing identified errors in recording medicines by staff. We saw that there were four omissions in recording during October 2015. These had been picked up during the monthly audit process. We saw that the provider had put appropriate safeguards in place to prevent this from happening again. The registered manager also audited medicines every quarter.

Team leaders told us that staff were only allowed to administer or supervise medicines once they had completed medicines training. Staff were also observed in the person's home by more experienced staff before being allowed to administer medicines alone. We saw that people's medicines had been recorded in their care plans. One relative told us. "She can do it [take medicines] herself and staff supervise and make sure she remembers."

Good

Is the service safe?

We saw that if people required as needed medicines, such as a tablet for a headache, this was recorded in their care plans. Care plans provided guidance for staff on when as needed medicines should be given and for what ailments.

Good

Is the service effective?

Our findings

People were supported by staff that were able to meet their needs. Staff told us and records confirmed they were supported through regular supervisions to look at people's on-going care needs and identify training and development needs. Supervisions were detailed and looked at care according to the Care Quality Commission's (CQC) key lines of enquiry. The key lines of enquiry provide a framework to look at best practice and identify where care could be improved. Staff had input into their supervisions and told us that they had monthly supervision that helped them be clear on the best way to support people. One staff member said, "It's when I am able to discuss what I've seen and what improvement I would like. We talk about the people I support." There were regular, detailed appraisals for staff. Appraisals helped staff identify training needs and performance for the year.

Records were kept of monitoring visits for care staff. Monitoring visits looked at all aspects of how the person's care was being delivered including; medicines administration, if the person was treated with dignity and manual handling. The team leader told us that if an issue was identified it would be addressed with the staff member in supervision. If the issue was serious then it would be addressed immediately. We saw staff records that showed that an issue around medicines recording had been identified and appropriate action had been taken.

The Mental capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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 authourised under the MCA.

We checked whether the provider was working within the principles of the MCA and whether any conditions on authourisation to deprive a person of their liberty were being met.

Staff had received training in the Deprivation of Liberty Safeguards (DoLS) and The Mental Capacity Act 2005 (MCA). One staff member said, "We can't assume that people don't have capacity. People can have capacity in some areas but not others. An assessment must be completed if we think that people are lacking capacity." People's capacity was not assessed by the service at the point of referral. The team leader told us that they were in the process of updating the referral form to include capacity. We saw evidence that the staff had requested MCA assessments for people. Staff told us that family members were involved in people's assessments and reviews where appropriate. If the person lacked capacity a best interests meeting would be held.

Staff understood what DoLS was and how it could impact on people's care. The provider did not generally apply for DoLS for people. However, we saw one person that the service had identified as requiring some restrictions for their safety. The registered manager had applied for a DoLS and the outcome of this had been carried through into the person's care plan.

Care plans showed if people required help with meal preparation when care staff visited. Some people were supported to cook meals and others required prompting to eat regularly. All staff were trained in food hygiene.

We saw that staff had a comprehensive induction when they started to work to ensure that they understood people's needs prior to working alone. The provider employed 10 full time care staff and also outsourced work to several other staff agencies. The London Borough of Enfield employees received a full induction including all mandatory training and understanding the needs of the people they would be working with. New staff shadowed more experienced staff before being allowed to work on their own. Agency staff received an induction to the service and an introduction to the people they would be working with. The team leader told us that they used the same agency staff, where possible, to maintain continuity of care. Agency staff were not supervised by staff at the service. However, we saw records of interagency working and communication around agency staff performance and competence.

Staff training records showed when staff had completed training and when it needed to be renewed. All staff had received mandatory training in areas such as, manual handling, Mental Capacity Act 2005 and health and safety. The team leader told us that new staff were beginning to work towards the new 'Care Certificate'. The Care Certificate

Good

Is the service effective?

sets out standards and competencies that health and social care workers should adhere to in their daily working life. Other staff had achieved National Vocational Qualifications (NVQ's) in health and social care.

When people had specific needs, they were supported only by staff that had been trained to meet these needs. For example, two people had epilepsy. All staff members that worked with them had completed epilepsy training. On talking to staff, they were able to explain what they would do if a person had a seizure when they were being supported. We saw that if people using the service were living with dementia, staff had received dementia care training.

People's care records had details of healthcare visits, appointments and reviews. Staff were aware of how to refer people if they thought their health needed attention. Staff told us, "I would tell the family if it was appropriate or contact the office for advice." Guidance given by professionals was included in people's care plans.

The registered manager ensured that staff knew how to refer people to other teams. We saw that when people's needs changed referrals were timely and documented in their care files.

Good

Is the service caring?

Our findings

Relatives told us that the thought the service was caring. One relative said, "We are very satisfied with the service we receive. The staff all care." Another relative said, "My [relative] is very happy with them, they are kind to him."

The team leaders and care workers told us about the importance of treating people with dignity and respect and making sure people were seen as individuals and had their needs met in a person centred way. One staff member said, "I don't discuss people's personal details with anyone unless they are involved in their care." Another staff member said "When we do personal care in people's homes, we make sure that the door is shut and we ask if they are ready for us to help them." Staff told us that 'consent to care' was an area that was covered in their induction. We saw that the provider had an 'intimate care policy'. This was created as a result of an issue arising and the service responding to the needs of both the care staff and the people they supported. One relative said, "My [relative] is always treated with respect by the staff, I would tell them if she wasn't."

Care plans were person centred and aimed at ensuring people maintained as much independence as possible. They noted what people were able to do by themselves and what they needed help with. People and their relatives told us they were involved in developing their care plans and identifying what support they required from the service and how this was to be carried out.

Care plans included information on people's religious needs. One staff member told us, "If the person has a religion we make sure it is in their care plan and we support them." Where possible, staff were matched to people according to their preferences. We saw that one person had requested a female care worker as she received personal care. The staff ensured that the person always had a female care worker.

We saw that care plans stated how people wanted their care to be delivered. One person's care plan said, 'I want staff to call me 10 minutes before they arrive'. Staff told us that they always called this person before arriving. Another care plan said that the person 'wanted staff to take their shoes off when in their home'. Staff told us that they take slippers with them and that, "It is their home and we respect what they [the people receiving care] want."

Staff that we spoke with knew people well and were able to discuss people's life histories as well as their personal preferences. One staff member said, "I've been working with him for a while and I know him well, I understand what he likes and wants."

We asked staff how they would work with lesbian, gay and bisexual people. One staff member told us, "We work with the individual, I don't label people. What would give me the right to treat them differently? It's about what support they need." Staff were positive about working with lesbian, gay and bisexual people.

Equality and diversity was discussed with people at a quarterly service user forum. We were told that the majority of people using the service were supported to attend. The provider brought in a theatre company to do a play on equality and diversity. Following this people were encouraged to talk about their views and appropriately challenge each other. Staff said, "This is what we do, talking to people with respect and showing people how it could feel for someone to be treated like that." Staff said that the forum was designed to, "Be fun and try and find out more about people's preferences and getting them more involved in their care."

Good

Is the service responsive?

Our findings

We looked at people's care plans and saw that staff responded to people's needs as identified. Where a person was unable to have input there were people identified that actively contributed to planning their care. Care plans were reviewed regularly and updated as changes occurred.

Care plans were written in a person centred way. Each person had a support plan that documented their care needs and a person centred plan called 'My Plan'. My Plan was a one page overview of the person that provided staff with key information about them.

People were encouraged to maintain relationships within the community. One relative told us, "They took her to a disco last week." Another relative said, "She loves going on the bus and shopping. Staff always take her out." One person's care plan said, 'I spend all Saturday with my family but I love to go shopping or do something in the community'. Care plans identified people's preferences and what they enjoyed doing. We saw that staff supported people to be as independent as possible.

People and relatives told us that they thought the service met their needs. One relative said, "They know [my relative] really well, what he likes and what his needs are." The provider assessed people's needs when they were referred to the service. A tailored package of care was devised according to the outcome of the assessment. People's initial assessment included physical care needs, practical needs such as, washing and meal preparation and overall wellbeing.

There had been one recorded missed visit since March 2015. The team leader told us that any missed visits were taken seriously and investigated. The provider had recently installed a new monitoring system to ensure that care workers attended visits. Carers logged on to the monitoring system when they arrived and logged out as they left. This allowed the provider to monitor whether that care workers were on time and spending the correct amount of time supporting the person. The team leader told us that it was people's choice if they wanted this system in their home. There were plans to discuss this with all people using the service.

Relatives told us that they knew how to complain. One relative said, "Yes, I know how [to complain]. There hasn't been anything though." Other relatives said, "I've had to complain once and they dealt with it" and "I had a problem with one carer and phoned the office. They sorted it out immediately and I was happy that they dealt with it so quickly." The provider had a complaints procedure in place. People using the service were provided with a booklet that gave detailed guidance on how to make complaints and comments. People were encouraged to raise any concerns or complaints during the quarterly service user forum. We saw that 10 complaints had been recieved since January 2015. Each complaint had been recorded in detail including actions and how the complaint had been resolved.

Good

Is the service well-led?

Our findings

Staff said that the registered manager promoted an open environment and, "Encourages the team to utilise our individual skills. We support each other and nothing is hidden. Even if we are doing something wrong, it is an opportunity to learn. The manager is very supportive." Another staff member said, "The manager is very compassionate and will go out of her way to help you." One relative said, "The manager is helpful when I call, always does her best."

The provider operated on on-call system for out of hour's issues that arose. This operates seven days a week between 17:00 and 09:00 and at weekends. In addition to the on-call system, one team leader was rostered to be 'on duty' for the week. This meant that the on-duty person remained in the office and was the main point of contact for care workers, relatives and people who used the service. They were responsible for following up calls and ensuring good communication. Staff told us that this had been a collective idea, implemented by the registered manager that had come out of a recent staff meeting following issues around people not being able to contact the office. Relatives told us that they could always contact staff in the office and someone was available when the office was closed.

The accident and incident records showed that the registered manager used accidents and incidents as an opportunity for learning and to change practice or update people's care needs. Procedures relating to accidents and incidents were clear and available for all staff to read. Staff told us that they knew how to report accidents and incidents.

An audit of the service had been carried out in May 2015 by 'private voluntary auditors'. This is a group of people, such as people who use services and carers, who audit social care services across the borough. This initiative was supported by the London Borough of Enfield. The results of the audit were positive and people said that they felt supported by the service that they received.

The registered manager completed quarterly audits. This included overviews of accidents and incidents, medicines, care plans and risk assessments, staff supervisions, appraisals, team meetings and safeguarding issues. The service operated a red, amber, green (RAG) system. If an issue emerged from the audits it was given a RAG status. Actions were put in place and the matter was discussed at team meetings.

Team leaders told us that following last winter, the registered manager had put in place a RAG system to identify people who needed critical care visits that could not be missed. There were contingency plans in place to ensure that people received care in case of emergencies.

We saw that in November 2015, surveys had been sent out to people and their relatives. The team leader told us that the information returned would be looked at and responses used as an opportunity to learn.

The office where the service was based was multidisciplinary. The London Borough of Enfield were promoting a 'joined up working' philosophy. Within the open plan office there were community nurses, the adult placement team, occupational therapists and psychology team. Many of the people who used the domiciliary care service were also helped by other teams based in the office. The team leaders told us that this meant that staff could discuss care needs quickly and ensure that referrals were quickly processed.

We saw that regular team meetings were held. Staff told us that they felt they could raise any issues and that the registered manager would listen to them. Another staff member said, "Team meetings are a time to come together and discuss things. The manager always listens."