Crossroads Care Cheshire, Manchester & Merseyside Limited

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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

Summary of findings

Overall summary

This inspection took place on 25 October and 1 November 2016 and was announced. This was to ensure someone would be available to speak with us and show us records. We visited the registered provider's office on 25 October 2016, and spoke with people who used the service, family members and staff on 1 November 2016.

Crossroads Care Cheshire, Manchester and Merseyside Limited provides care to people living in their own homes. On the day of our inspection there were 67 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Crossroads Care Cheshire, Manchester and Merseyside Limited was last inspected by CQC on 9 January 2014 and was compliant with four of the regulations inspected at that time, but was non-compliant with Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers.

Accidents and incidents were appropriately recorded and investigated. Risk assessments were in place for people who used the service and staff and described potential risks and the safeguards in place. Staff had been trained in safeguarding vulnerable adults. Appropriate procedures were in place to ensure people received medicines as prescribed.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The registered provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. Staff were suitably trained and received regular supervisions and appraisals.

The registered provider was working within the principles of the Mental Capacity Act 2005 (MCA).

Staff were aware of people's nutritional needs. Care records contained evidence of visits to and from external health care specialists.

People who used the service, and family members, were complimentary about the standard of care at Crossroads Care Cheshire, Manchester and Merseyside Limited. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care records showed that people's needs were assessed before they started using the service and care plans were written in a person centred way. Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs.

People who used the service, and family members, were aware of how to make a complaint and there was an effective complaints procedure in place.

Staff felt supported by the registered manager and were comfortable raising any concerns. People who used the service, family members and staff were regularly consulted about the quality of the service. People who used the service, and family members, told us the management were approachable and understanding.

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 who used the service received care and support from familiar staff and the registered provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated and risk assessments were in place for people and staff.

The registered manager was aware of their responsibilities with regards to safeguarding and staff had been trained in how to protect vulnerable adults.

People were protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People were supported by staff with their nutritional needs.

People had access to healthcare services and received ongoing healthcare support.

The registered provider was working within the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People had been involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they started using the service and care plans were written in a person centred way.

Activities were in place for people who used the service, based on their individual needs and preferences.

The registered provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The service had a positive culture that was person-centred, open and inclusive.

The registered provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff told us the registered manager was approachable and they felt supported in their role.

The service had links with the community and other organisations.

Crossroads Care Cheshire, Manchester & Merseyside 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 registered 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 25 October and 1 November 2016 and was announced. This was to ensure someone would be available to speak with us and show us records. One Adult Social Care inspector carried out this inspection.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. Information provided by these professionals was used to inform the inspection.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to inform our inspection.

During our inspection we spoke with three people who used the service and three family members. We also spoke with the registered manager, head of operations, service coordinator, care coordinator and three care staff.

We looked at the personal care or treatment records of four people who used the service and observed how people were being cared for. We also looked at the personnel files for five members of staff and records relating to the management of the service, such as quality audits, policies and procedures. We also carried out observations of staff and their interactions with people who used the service.

Good

Is the service safe?

Our findings

Family members we spoke with told us they thought their relatives were safe with Crossroads Care Cheshire, Manchester and Merseyside Limited. They told us, "Safe? Oh yes, I do", "[Staff member] makes sure I'm safe" and "Yes they do [keep people safe]".

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant the registered provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We discussed staffing with the registered manager and looked at staff rotas. The registered manager told us vacancies and absences were covered by the permanent staff at the service and agency staff were not used. The registered manager told us they relied on the good will of staff to change shifts or work extra hours to cover absences. Staff we spoke with confirmed this and told us, "They ask if we can pick up extra. It is always near where we work. They are very reasonable about it and I like that."

The registered manager told us people who used the service knew which member of staff would be visiting them as staff rotas were sent out to people and their family members every week. People who used the service and their family members told us, "I always know which staff are coming. If there's a change, they ring me" and "I usually have the same member of staff. I always know who's coming out". This meant there were enough staff with the right experience and knowledge to meet the needs of the people who used the service.

The service had a business continuity plan in place to deal with the potential impact that may be caused by a specific incident or reduction in staffing levels. This set out the areas of responsibility for management and staff in implementing the plan or assisting in the implementation of the plan.

The registered provider's health and safety policy set out the service's approach to the health, safety and welfare of its staff and visitors to the registered provider's premises. The policy included risks from workplace hazards and safety management systems, such as accident and incident reporting and recording, and risk assessments.

Risk assessments were in place for people who used the service and staff and described potential risks and the safeguards in place. For example, staff lone working and the potential risks for staff when visiting people in their own homes. The risk assessment for staff visiting people in their own homes considered street

lighting, entrance to and exit from the property, fire safety, utilities, appliances, control of substances hazardous to health (COSHH), medicines, mobility and behaviour. People's risk assessments included safe handling, behaviour management and risks from social outings, and included identified hazards, what the identified risk level was and measures required to reduce the risk. This showed that potential risks to staff and people who used the service had been taken seriously by the registered provider and appropriate risk assessments put in place.

We saw a copy of the registered provider's safeguarding policy, which described management and care staff's responsibility to make sure people who used the service were protected from abuse and kept safe at all times. We looked at safeguarding records and saw incidents had been appropriately dealt with, and CQC had been appropriately notified of all the incidents. We discussed safeguarding with the registered manager and found they understood safeguarding procedures and their responsibilities.

Accidents and incidents were recorded and a summary of all the accidents and incidents was provided at the registered provider's care quality sub committee meeting. The sub committee looked to see if there were any trends and whether any training was required for staff if there were any recurring themes.

The registered provider had a medication guidance policy and procedure for staff for staff to follow to ensure medication was administered safely and appropriately to people who used the service. Although we did not observe medicines being administered, we looked at people's care records and saw medication support plans were in place. These described the level of support required from staff in supporting people with their medicines.

Medicine administration records (MAR) were in people's care records. A MAR is a document showing the medicines a person has been prescribed and records when they have been administered. MARs included information on the person, such as whether they had any allergies and contact details for their GP, and administration records such as the name of the medicine administered, the dosage, route and staff initials to confirm it had been administered.

We looked at training records and saw staff had been trained in administering medication. Senior staff carried out audits of MARs and the registered manager told us a training session was being held the following day for office and senior staff regarding the completion of MARs and what to look out for when completing audits.

This meant people were protected against the risks associated with the unsafe use and management of medicines.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. Family members told us, "I am very happy with all the staff", "The staff are very good" and "I've found them all to be good".

Staff received mandatory training in personal care, health and safety, first aid, administration of medicine, safeguarding, moving and handling, communication and behaviour management. Mandatory training is training that the registered provider thinks is necessary to support people safely. Additional training was provided for specialised tasks such as percutaneous endoscopic gastrostomy (PEG). PEG is a tube that is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. Family members we spoke with told us staff were well trained. One family member told us, "I've got pretty high standards. I think Crossroads are aware I like continuity and well trained people."

The registered provider had a workforce development plan, which was used to analyse staff training needs and create individual development plans. The registered provider produced a report, which was sent to the registered manager and showed what training was required for individual staff and when it was required by.

Training needs were also identified via staff supervisions and appraisals. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. We saw staff received regular supervisions and appraisals. Staff told us they received regular supervisions and one member of staff told us, "The door is always open so you don't have to wait for your supervision if there is a problem."

New staff completed an induction to the service, which included the registered provider's four day induction programme and completion of mandatory training. All new staff were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training for new staff working in health and social care. This meant staff were supported in their role.

People's wishes regarding their dietary needs were recorded in care records. For example, "I would like staff to assist with preparation and heating up meals and drinks" and "I would like to maintain a healthy diet through eating healthy food of my choice". We saw in one person's referral and assessment form that they were at risk of silent aspiration due to a weak swallowing reflex. The person's eating and drinking care plan provided clear instructions to staff on how to support the person. For example, supervise the person at all times when eating, the person was to have a chopped/mashed diet, a closed beaker was to be used for fluids with a thickener added and the person was not to have snacks between meals apart from fruit. This meant people were supported by staff who were given clear guidance about their nutritional needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. Mental capacity support plans were in place for people and recorded whether the person had the capacity to make decisions for themselves and whether they received any support from family members. The registered manager told us they worked closely with families and social workers and liaised with social workers if staff had any concerns regarding a person's mental capacity.

We observed that the service had sought consent from people for the care and support they were provided with. Consent to care and support plans were in place for people and recorded whether the person agreed with the content of their care records. Where the person was unable to sign, it was recorded whether the person had given verbal consent and what action had been taken by staff to ensure the person agreed.

One of the care records we looked at stated the person had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). We did not see a copy of the DNACPR as it was held at the person's home address however the information in the care records stated it had been signed by the person's GP.

People's care records included communication support plans, which described how people communicate, their preferences and how staff could support people with their communication. For example, "[Name] can communicate most of the time but can become confused due to short term memory loss. Please give [Name] time to respond" and "[Name] is a friendly person and likes to have a chat". Family members told us staff and management communicated with them very well.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of involvement from external specialists including GPs and district nurses.

Good

Is the service caring?

Our findings

People who used the service, and family members, were complimentary about the standard of care provided by Crossroads Care Cheshire, Manchester and Merseyside Limited. They told us, "They care", "[Staff member] is absolutely excellent" and "I had a choice of carer if I wanted it, which is great".

Staff we spoke with were aware of people's individual needs and told us people were able to make choices, for example, what they had to eat, what clothes they wore and what activities they carried out. People who used the service told us, "I choose what I want to wear and they collect it for me" and "Yes, I get to choose what I want".

Staff told us that respecting the privacy and dignity of the person they were caring for was very important and gave examples of how they did this. For example, "We don't talk over the person. We respect them", "You cover all areas [of the body] to respect their dignity", "We've got to respect our clients and respect their wishes. We are accountable for any actions".

We asked people and family members whether staff respected the privacy and dignity of people who used the service. They told us, "Privacy and dignity? They are very good at that", "All of the staff I've got are very good, some are exceptional" and "Once I'm in the shower [staff member] closes the door and gives me privacy".

People had emotional well-being support plans in place which provided guidance to staff on promoting people's dignity and how people wanted to be supported. For example, "Have a chat, allow [Name] time to process the information", "Please treat [Name] with dignity and respect at all times" and "Offer choice whenever possible". One person who used the service used a wheelchair to mobilise around their home and the person's care records stated, "Staff to support [Name] while in their home with putting a pillow under their feet/heels so they do not rub on the wheelchair." This meant that staff treated people with dignity and respect.

People's autonomy and independence support plans described how people wished to remain independent and what support they required from care staff. For example, "[Name] will like to continue to make choices about daily living activities and will ask for help if they need it", "[Name] would like to remain as independent as possible" and "[Name] would like to be supported to make choices and express their needs". We saw one person's care records stated the person occasionally had to be persuaded to undertake certain tasks but if they refused, it was to be recorded on the report sheet and the office informed.

Family members we spoke with told us staff supported their relatives to be independent. This meant that staff supported people to be independent and people were encouraged to care for themselves where possible.

The registered manager told us none of the people using the service at the time of our inspection visit were receiving end of life or palliative care.

Good

Is the service responsive?

Our findings

The service was responsive. We saw that care records were regularly reviewed and evaluated.

People's needs were assessed before they moved started using the service. We saw copies of referral and assessment forms, which recorded important information about the person such as their personal details, medical conditions, care needs, likes and dislikes and details of any healthcare professionals involved in their care. This ensured staff knew about people's needs before they started using the service.

People's support plans described the area of support required, the person's desired outcomes from the support and how the outcomes would be achieved. Support plans included personal care, continence, mental capacity and the ability to make decisions, skin care, eating and drinking, communication, medicines, mobility, religion and culture, and autonomy and independence.

For example, one person had a mobility support plan in place due as they required assistance with transfers in and out of bed. The support plan described that the person required two members of staff to assist with transfers and what equipment should be used. The person also used a wheelchair to mobilise inside and outside their property and staff were instructed to supervise the person at all times and ensure they were wearing their seatbelt.

Another person was at risk of pressure sores and their skin care support plan provided instructions to staff on applying barrier cream to the pressure areas and the support required to assist the person in mobilising around their home.

Support plans described people's social, religious and cultural needs, and what interests and hobbies people liked to take part in. The support plans also provided instructions for staff in how to support people with their social needs and interests. For example, "[Name] likes to go to the pub with their daughter", "Please turn the television on and put it on channel 103", "Choice should be given to [Name] around all aspects of daily living" and "[Name] likes to play dominoes, watching tv and socialising". This meant people were protected people from social isolation.

Staff completed report sheets during each care visit. These recorded the date, start and finish time and comments such as what the person was doing on arrival and what the member of staff did for the person, for example, carried out personal care, assisted the person with a shower, took part in activities and what meals were prepared.

We saw a copy of the registered provider's compliments and complaints policy and procedure. This provided information of the procedure to be followed when a complaint was received. Complaints were recorded on individual complaints forms and entered on the registered provider's electronic system. We saw there had been one complaint and five compliments recorded at the service in the previous 12 months. A complaints tracking form was used to record how the complaint was received and important dates in the complaints process. For example, the date of the acknowledgement of the complaint, the date of the written

response and the outcome of the complaint. The registered manager told us complaints were discussed and reviewed at the registered provider's care quality sub committee meeting.

People, and their family members, we spoke with were aware of the complaints policy but did not have any complaints about the service. This showed the registered provider had an effective complaints policy and procedure in place.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. The registered manager was new in post and was in the process of establishing links with local organisations and groups and building on relationships put in place by the previous registered manager. These included local voluntary community groups and a health and wellbeing forum. The service had also signed up to the Social Care Commitment. The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services.

The service had a positive culture that was person centred, open and inclusive. People who used the service, and their family members, told us, "We are able to communicate very well with each other", "If I have an issue, I can phone up and come in and talk about it. It's two way", "Yes, I think they are a very good organisation", "There's always somebody at the end of the phone" and "Very nice and cooperative".

Staff we spoke with felt supported by the registered manager and told us they were comfortable raising any concerns. They told us, "They [management] are very understanding. There is very good communication and communication with each other [staff] is very good", "I always feel like they are approachable in the office. You can be very isolated when out and about but you can call in any time. It gives you peace of mind", "Yes, they have an open door policy", "I really do feel comfortable with them [management]" and "They are very professional".

Staff were regularly consulted and kept up to date with information about the service. Staff meetings were held every three months. We looked at the minutes for the most recent meeting held in October 2016 and saw items on the agenda included an update from the registered manager, issues relating to people who used the service, policy and procedure updates, health and safety, recruitment, holidays and any other business.

We looked at what the registered provider did to check the quality of the service, and to seek people's views about it.

A quality audit had been carried out by the registered provider's head of operations and registered manager in June 2016. This was based on the CQC five key areas and included actions such as checking quarterly audits were completed for each person who used the service and the policies and procedures folder was updated quarterly. Quarterly audits of care records included checks of referral and assessment documentation, support plans, risk assessments and reviews.

The service had applied for the Carers Trust Quality Award, which is an internal quality assurance process that audits the quality of financial management, governance and care. The registered manager told us they were waiting for the outcome of the audit process.

Management and senior staff carried our regular spot checks of staff in the workplace. These checked

whether staff arrived on time, carried their identification care and were wearing the correct uniform, and personal protective equipment (PPE). Staff were observed carrying out their role including moving and handling techniques, administration of medicines and whether they followed the person's care plan.

People who used the service, and their family members, were asked to complete a service evaluation in 2016. This included questions on each of the CQC five key areas, as well as questions on the standard of care, communication and whether people were treated with dignity and respect. Analysis was carried out on the responses received and showed that the majority of responses were overwhelmingly positive and personalised care was the priority for the majority of respondents.

People who used the service, and their family members, we spoke with told us they had received questionnaires to complete. They also told us they were given regular opportunities to feedback on the quality of the service.

An annual employee survey took place, the most recent was in November and December 2015. This included questions on communication, training and development, leadership, job satisfaction and workload, and analysis had been carried out on the responses to identify any areas of concern. We saw the majority of responses were positive.

This demonstrated that the registered provider gathered information about the quality of their service from a variety of sources.