London Care Limited

# London Care (Holloway)

## 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

London Care is a domiciliary care agency which provides services to over 300 people, mostly in north London. The service predominantly caters for the needs of older people but also younger people with disabilities or other support needs.

This inspection was short notice which meant the provider and staff did not know we were coming until shortly before we visited the service and our inspection was carried out on 8th January 2016. At the last inspection on 12 January and 9 February 2015 the provider was not meeting all of the requirements we looked at. At that time we found breaches of Regulation 10 (Now regulation 17 of the amended regulations - Good governance) and Regulation 11 (Now regulation 13 – Safeguarding service users from abuse and improper treatment) We had also made three recommendations in the areas of Safe, Effective and Well – Led. At this inspection we found that the provider had taken action to address the breaches and respond to the recommendations.

At the time of our inspection there was a registered manager in post. 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.

From the telephone discussions we had with people using the service and relatives we found that people were usually satisfied with the way the service worked with them. People felt able to contact staff at the agency to discuss anything they wished to and care workers were usually viewed as having the right skills to care for people.

In all of the care plans we looked at we found that the service had improved. Risks associated with the care to be delivered were identified and reviewed and were changed whenever any risks were assessed as having changed.

The service had access to the organisational policy and procedure for protection of vulnerable adults from abuse. We asked staff about how they would recognise any potential signs of abuse. All but one member of staff was able to confidently tell us about what they would do; the one who didn't at first gave clearer responses when prompted. The care coordinators we spoke with said that they had training about protecting vulnerable adults from abuse and were able to describe the action they would take if a concern arose.

We spoke with the manager who explained the system used by the provider for both mandatory and optional training courses. We found the mandatory training covered core skills and knowledge for staff and induction training was in line with the Skills for Care Common Induction Standards and the care certificate.

The agency had detailed policies, procedures or information in relation to the Mental Capacity Act 2005

(MCA). The provider informed us that they were aware of three people using the service who were subject to enduring power of attorney. It should be noted that the agency would not have responsibility for making applications under this legislation. However, they would have responsibility for ensuring that any decision on the MCA 2005 were complied with. Care staff we spoke with demonstrated understanding of this area.

The people that we spoke with were generally very satisfied with the care workers they used and their knowledge and ability to provide care and support.

The care plans we looked at drew attention to individual needs such as how people communicate, their cultural identify and first language. The care plan format contained a short pen portrait of the person as part of the information available to care staff. This helped to provide information which assisted care workers to form a good rapport with the people they cared for.

We found that any complaints that had been made in the last year had been responded to appropriately.

The care provided by staff was clearly set out in all the care plans that we looked at. This included information about people's preferences and individual needs. For example, the times when carers were to call at people's homes to deliver care was stated along with the numbers of carers required.

Staff members and professionals that we spoke with told us they felt improvements had continued to be made and clear and effective communication between care workers and office based agency staff was usually effective.

There was a clear management structure in place and staff were aware of their roles and responsibilities. Further changes had been made recently with the aim to address issues around the structure and co-ordination of the service.

In discussion with the manager and care co coordinators during our inspection we were told about, and shown, the monitoring systems for the day to day operation of the service. Staff had specific roles and responsibilities for different areas and were required to report to the manager about the way the service was operating and any challenges or risks to effective operation that arose. The systems included monitoring visits and phone calls to people using the service, ongoing contact with placing authorities and monitoring of visits to ensure they were happening at the right time. If late or missed calls arose we found that these were responded to quickly.

The service sought people's views at least annually and we saw individual examples of feedback that had been received. There was now a formalised system for carrying out recorded surveys apart from people using the service, either quarterly or at least annually. Feedback was also being obtained from staff employed and other professionals in contact with the service.

As a result of this inspection we found that the service was meeting all of the regulations that we looked at.

## 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. Care staff we spoke with able to demonstrate improved day to day working knowledge about how to respond to concerns about abuse.

Any risks associated with people's needs were assessed, updated at regular intervals and at times when changes to care needs were identified.

The service had access to the organisational policy and procedure for protection of vulnerable adults from abuse as well as those used by the local authorities who contracted with the service.

### Is the service effective?

Good

The service was effective. The frequency and consistency of staff supervision and appraisal had improved which meant that staff were supported as they should be.

The service did well to respond to people's care and support needs, care plans accurately reflected the service that people were provided with. There was improved awareness of care staff about the Mental Capacity Act 2005 (MCA) and how this related to their day to day work.

### Is the service caring?

Good

The service was caring. The view from people using the service and their relatives was of a service that cared for people and respected their individuality and views about how they should be supported.

We saw a clear communication policy that included people's preferred methods of communication, which were documented, and the need for staff to always communicate with people effectively.

### Is the service responsive?

Good

The service was responsive.

The people who were using this service each had a care plan. The plans described people's specific needs and reflected each person's lifestyle and preferences for how care was provided. Care plans were reviewed and updated at regular intervals and were unique to the person as an individual. This helped to ensure that information remained accurate and reflected each person's current needs.

## Is the service well-led?

Good

The service was well-led. Communication between care workers and office based staff had improved significantly and this minimised any detrimental impact on people using the service from poor communication.

The service had implemented systems for obtaining feedback from staff, health and social care professionals and other stakeholders. This meant that much more was being done to seek views about the quality of the service.

# London Care (Holloway)

**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.

The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the manager and other people we needed to speak with were available. We carried out an inspection visit to the agency on 8 January 2016. This inspection was carried out by three inspectors, two visited the agency offices and one carried out telephone interviews of people using the service and care workers.

Before the inspection, the provider completed a Provider Information Return (PIR). 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 looked at notifications that we had received and communications with people's relatives and other professionals. These included information from local authority safeguarding teams, other notifications and examples of how the service had responded to complaints.

During our inspection we spoke with two people using the service, four relatives, four care workers, two care co coordinators, the registered manager and received feedback from a local authority commissioning team manager.

We gathered evidence of people's experiences of the service by conversations we had with them and by reviewing other communication that the service had with these people, their families and other care professionals.

As part of this inspection we reviewed ten people's care plans and care records. We looked at the induction, training and supervision records for the staff team. We reviewed other records such as complaints information, quality monitoring and audit information.

Good

# Is the service safe?

## Our findings

All of the people we spoke with had positive comments about the service. People thought the service had continued to improve since the current manager was appointed in the spring of 2014.

A person using the service told us, "I would say we are very lucky. We get the same lady all the time. She is lovely, very caring and gentle."

A relative told us, "The care workers are really brilliant. Their task only takes 5/10 minutes and some of the carers help me with other tasks such as vacuuming or tidying up the kitchen. They always chat [to the relative] and have a laugh with her." Another relative told us, "the main carer is absolutely brilliant. When the main carer is on holidays sometimes the experience of the cover provided can vary. But I'm there all the time."

Almost everyone we spoke with said they would be more than confident to speak up about any form of abuse or harm to either themselves, if they were using the service, or their relative using the service.

The agency had introduced a new care planning format prior to our previous inspection. The risk assessment records we looked at had been transferred to this format which included an assessment of risks for the person receiving care and for staff.

At our previous inspection we recommended that the service seeks advice and guidance from a reputable source about risk assessments clearly showing the general common potential risks considered and identify what is, or is not, specifically relevant to each person. We saw in the care plans where risks had been identified and these were also worded as instructions for carers. This was an improvement on what we had previously seen. In most of the care plans we saw that this had improved. However, in three cases there was a lack of clarity when a potential concern of an increased risk of falls had been noted, but no follow up action had been recorded. We raised this with the manager to address, which they agreed to examine and refer to the care co-ordinator for each of these people. We saw that risks for staff in delivering care were clearly noted. For example where risks due to people's behaviour might be identified this was noted and action to minimise risk and staff response was included.

Care staff we spoke with said "I make sure people are safe and protected and also myself. It's about using common sense" and "my role is to keep people secure from abuse for example, mental, sexual or financial."

The service had access to the organisational policy and procedure for protection of vulnerable adults from abuse, which was included in the handbook given to each care worker. As the service provided care and support to people living in four boroughs in London we looked at whether the service knew who to contact if concerns arose and found that they had the information to enable this to occur. We asked staff about how they would recognise any potential signs of abuse. The care coordinators we spoke with said that they had training about protecting vulnerable adults from abuse and were able to describe the action they would take if a concern arose. At our previous inspection we had found a breach of regulation 13 in relation to

safeguarding service users from abuse and improper treatment as not all staff were suitably aware of what they should do if they believed that people were at risk of abuse. At this inspection all but one of the care workers we spoke with demonstrated awareness of what to do if they became concerned about a person being at risk of abuse. We advised the manager about the worker who had not been sufficiently aware of safeguarding.

There had been a significant reduction in the number of safeguarding alerts which we had received from the service in the last year. The small number which had been raised had been responded to appropriately and the service had co-operated fully with this process.

The service had arrangements in place to deal with emergencies, whether they were due to an individual's needs, staffing shortfalls or other potential emergencies. We were told by staff that they operate a 24 hour; 365 days per year on call service. No one we spoke with who used the service told us of any continuing difficulties with having the care staff that they or their relative needed.

A small number of comments were made about occasional missed calls. However, it appeared that this had been an error by staff not having checked their rota correctly and people told us that the agency had responded. The service had a logging system in place which raises an alert if a care worker does not log in their visit to a person when they arrive and leave. This enables staff based at the agency office to contact the care worker to verify what has happened and to respond to a late or missed call. A stakeholder told us that there were occasional incidents of this nature but they were responded to and there were no significant concerns about the overall ability of the service to respond to the calls expected to be made.

The service was not responsible for obtaining medicines on behalf of anyone using the service. The need for the carer to prompt the person to take their medicines was clearly set out within the care plans, which had been agreed with the person or their representative in question. The log books which recorded the care delivered showed that people who required prompting to take their medicines had been reminded by the staff providing care. None of the files we looked at showed that staff were required to support a person in physically taking their medicines. The provider had a medicines policy and procedure in place and the care co-ordinators were able to talk us through this. Records showed that staff were trained in the provider's medicines policy and this clearly described the responsibilities of staff.

Good

# Is the service effective?

## Our findings

People said that staff were suitably skilled to provide their care. However, one person believed that carers should know more about diabetes as they had to repeat their explanations when new staff came to work with them.

The manager who explained the system used by the provider for both mandatory and optional training courses. The service maintained a data base which logged all staff training and if staff had either not completed a particular training course or had not attended refresher training the system flagged this for attention. We found that as a result of this staff were issued with a reminder to book onto the training and this was followed up with them. We found the mandatory training covered core skills and knowledge for staff and induction training was in line with the Skills for Care Common Induction Standards.

A care worker told us, "the carers are all very nice people and well trained. The staff in the office are professional." Other staff also confirmed arrangements for training and supervision.

The staff training records showed that most staff had core training and updated training at periodic intervals. This training was provided by suitably experienced staff working at the service, external training providers and a local authority. This meant that staff were supported to develop the skills and knowledge required to provide the most appropriate care for people. The staff training records also listed the dates by which refresher training had to be undertaken and this supported the provider's aim to ensure that people were only supported by staff with the necessary skills. Staff told us that they felt that training opportunities provided to them gave them the knowledge they needed to provide care and support.

We talked with the registered manager and two care coordinators about how staff were supported. We were told that they were in regularly contact with care staff. We found from looking at staff supervision records that this had greatly improved with a clear expectation upon all staff that supervision was important and should always be a priority. We found that staff were receiving individual quarterly supervision and we also found that staff appraisals were occurring annually.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf for 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 lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The agency had detailed policies, procedures or information in relation to the Mental Capacity Act 2005 (MCA). The provider informed us that they were aware of three people using the service who were subject to enduring power of attorney. It should be noted that the agency would not have responsibility for making applications under either of these pieces of legislation; however, they would have responsibility for ensuring that any decision on the MCA 2005 were complied with. At our previous inspection we recommended that the agency seek guidance from a reputable source to ensure that staff had an increased awareness of the

policies, procedures and information in relation to the Mental Capacity Act 2005 (MCA). We found at this inspection that care staff we spoke with demonstrated a better understanding of these areas and records showed that training was being provided.

People using the service and relatives said they were usually very satisfied with the way in which their care was reviewed and how they were consulted. We were told, "she [the care worker] never rushes and does a good job", "they are very, very good" and "they are open and honest."

We asked care staff how they ensured that people receive the care they required. We were told, "If a person asks me what they should do, I have no right of wish to tell them what to do. I will tell them it is your decision" and "If I am having a week off and one of my regular clients' needs to go to appointments, I arrange for one of my colleagues to escort them." Care staff also gave us practical examples of what they do, such as consulting about people's care needs and helping people with day to day matters like making appointments.

The care co-ordinators told us they had a rigorous system in place with field assessors who routinely spot checked the work of individual care workers. On care plans we viewed we found this was happening. Each person's care package was checked at least annually and more regularly if there were specific concerns. Staff told us that each person also received annual phone calls to obtain direct feedback about their care. We saw reports of the outcome of these phone calls and found that feedback was acted upon. The care plans we looked at showed that consent to care and support was being obtained.

Care staff did not assist people with preparing their meals, other than heating microwave meals in most cases. In the care plans we looked at which mentioned the need for staff to support a person with their food, we saw that people had been involved with decisions about the food they ate and their preferences were clearly set out.

The service did not take primary responsibility for ensuring that health care needs were addressed. However, the service required that any changes to people's condition that were observed by staff when caring for someone were reported to their relative or the agency. We discussed this with staff who told us that most people were in touch with a range of other health professionals who could alert the provider of any concerns and care workers were also required to report in any concerns about the person they observed. Conversations we had with care workers, and records, showed that they did this and were aware of what they should do, as well as giving examples of action they had taken.

Good

# Is the service caring?

## Our findings

The people that we spoke with who used the service did not make any comments specifically about how caring they thought staff were. However relatives told us, "yes, they are definitely caring.", "yes, they are very good. I'm there constantly - they do care." "They often spend more than an hour as they finish everything" and "[my relative's] privacy and dignity are definitely respected."

Care staff had a good understanding of what it means to be caring. We were told, "my clients come from very different backgrounds, but I am always on the same level as them. I am kind and nice to everyone and they are to me as regards to my culture." We were also told, "It's a two way thing. I work quite well with my clients. I know their interests" and "I do a lot of personal care such as washing and showering and try to ensure the dignity is protected."

Care plans drew attention to individual needs such as how people communicate, their cultural identify and first language. The care plan format, which had been introduced just prior to our previous inspection, encouraged a short pen portrait of the person to be included as part of the information available to care staff. This was being used across the care plans we looked at which helped to provide information that assisted carers to understand the way in which people preferred to be cared for and their heritage.

We saw from the log books, which care staff used to record their day to day support for people, we saw that people received their care from the same carers most of the time. Some people told us that there were occasional issues when care workers were replaced by unfamiliar staff. People told us that this was not a regular problem but did recall incidents in the past where this had happened.

We saw that many of the people or their representatives had signed to say that they had been involved in discussions and decisions about their care although this was not consistent across all the files we looked at. Staff told us that each person received a comprehensive file of information about the services available from the provider and what they could expect about the provision of their care. Staff told us that this information was explained to each person. This was confirmed in the records which showed that detailed information was contained in the information pack about the service on offer and this was carried through to what people had expressed as their preferences in the care plan. We noted that information was also displayed in different languages telling people how to obtain this information in a translated format if English was not their first language.

One of the local authorities in which the service provides care has a 'Dignity in Care' annual award that people receiving care can nominate care workers to receive. Five care workers had been nominated at the time of the inspection by people to receive this award. The comments showed that these staff were very highly valued for their caring attitude and the quality of their support to people.

Good

# Is the service responsive?

## Our findings

Everyone we spoke with was usually confident that any complaints or concerns were dealt with in a timely manner, although most people had not felt the need to raise any complaints. People told us, "We have no cause for complaint", "I have no cause for complaint, I have the number to call" and "I have their number and they always pick up. They are open seven days."

The provider's complaints policy had been most recently updated in October 2015. We looked at the complaints record and found that complaints had been made in the last three months. The manager informed us that most of these had been about easily resolved issues and we found that this had been the case. We saw that the complaints had been resolved with almost no further action required in all but one case. We found that when this had happened that appropriate action had been taken in response.

All office based staff were expected to complete specific qualifications (a diploma, level three, in business administration in health and social care). The service divided the branch into patches according to post codes providing specific coordinators and field supervisors for each patch. We saw that these changes had been largely completed. The registered manager informed us that where there was newly acquired work in geographical areas where staffing levels were not yet sufficient that they were not taking new clients until these resources were in place.

The care to be provided by staff supporting each person was clearly set out in all the files we looked at. This included information about people's preferences and individual needs. We saw from the log books which recorded the care given that care was provided in line with these instructions. The log books showed that people were cared for by the same care workers most of the time. This helped to ensure staff knew how to support a person and to build up positive relationships.

We asked two care co-ordinators and the manager about how they ensured that people received the care they required. We were told that there was a rigorous system in place with field assessors routinely spot checking the work of individual care workers. We found by looking at spot check records that this system was in place and being used. Each person's care plan was reviewed at least annually or more frequently if required especially if there were specific concerns. Care plans were reviewed when there were changes to the times staff visited or a change of care workers or numbers of care workers required to visit. There was involvement of family members where required. A relative told us, "they review the care plan a couple of times per year. They are very good."

All of the staff we spoke with talked about people who used the service in a polite and respectful way. Care staff told us "the care plans are regularly reviewed and if a situation arises, it's reviewed asap but usually every three months" and "If someone wanted to complain I would give them the numbers to call if they wanted to."

Good

# Is the service well-led?

## Our findings

Most people we spoke with could recall giving feedback to the service. We were told, "they invite me to regular meetings but I don't go as I have my relative to look after", "I think they're really good. It's only when there is cover by other staff, however we are given notice when the main carer goes away and I am always there", and "I have the number for them but I seldom use it."

Care staff told us, "I enjoy the job and I am quite passionate about care. Sometimes, I always include the client in my work" and "the staff in the office are professional." One member of staff said they felt there could be more praise by the agency management although another told us they received a letter of commendation whenever a client praised their work.

Staff told us that each person also received quality assurance phone calls during each year to obtain direct feedback about their care. We saw reports of the outcome of these phone calls and noted that the format of the reports extended their purpose to include a review of the adequacy of the level of care. This noted any potential changing needs as well as checking that current care instructions were being properly carried out. This was an example of how these reports had informed changes.

At our previous inspection we recommended that the provider seek views of care staff about the effectiveness of communication between the agency and staff. At this inspection we found that staff and external professionals that we spoke with told us they felt improvements had continued to be made to the service. When we spoke with people using the service or their relatives we were not told of any concern about communication. A local authority commissioning manager told us there were some minor difficulties about missed calls but as these were irregular and only very occasional they did not think it was a significant issue.

There was a clear management structure in place and staff were aware of their roles and responsibilities. Changes had continued to be made to the structure and co-ordination of the service. The views of people using the service, relatives, staff and other care professionals reflected an increased confidence and trust about the effectiveness of the agency and how it was run.

In discussion with the manager during our inspection we were told about, and shown, the monitoring systems for the day to day operation of the service. Staff had specific roles and responsibilities for different areas. They were required to report to the manager about the way the service was operating and any challenges or risks to effective operation that arose.

At our previous inspection we had found a breach of regulation 17 which relates to good governance as the service had not been seeking the views of people using it, relatives or other stakeholders. The registered manager told us that they sought people's views at least annually and we saw individual examples of feedback that had been received. There was a formalised system for carrying out surveys of people using the service, relatives, staff and other professionals. We looked at the most recent survey of people using the service which was collated and published in May 2015. This showed that there was a usually high degree of

confidence and satisfaction with how the service was run.