

Workwise Healthcare Limited

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

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

About the service

Workwise is a domiciliary care agency. The service supports people receiving personal care in their own home. At the time of the inspection, 96 people were receiving support with personal care. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found

'As needed' medicines were not managed safely, medicine records did not provide clear guidance to staff. Care plans guided staff on how to meet people's daily routines and preferences. However, care plans lacked detail on people's individual health conditions and how staff should respond to these. The registered manager has told us that they intend to resolve this.

Staff had made decisions for people who experienced confusion. However, documentation of people's ability to make decisions had not followed the principles of the mental capacity act. Systems were in not fully place to clearly assess and support people's decision making if needed. This puts people at risk of their decision making abilities not being effectively assessed.

The registered manager and staff were aware of their responsibilities and worked hard to create a good quality service. We identified concerns with medicine records, care plans and mental capacity assessments. We also identified concerns with the end of life policy and there was no evidence that people had been asked about their end of life wishes. The registered manager's oversight and auditing of these areas had not identified these concerns. The concerns highlighted on inspection were responded to promptly and evidence sent that changes were being made. We will review the impact of this at our next inspection.

People told us that they felt safe at the service. Good hygiene practices were followed to keep people safe from the risk of infection. Incidents were reviewed, and action taken to keep people safe.

There were enough staff at the service and staff arrived at calls in a timely way. Some missed calls had occurred at the service, which meant staff had not arrived at the person's house as expected. The registered manager had reacted appropriately to each circumstance and advised they were working to ensure this did not reoccur.

Most people told us that regular staff attended. These staff knew their needs well and had built a good relationship. People told us that when these staff had annual leave of sickness, new staff were sent to them. People reported that care was still a good quality however these new staff did not know their needs as well. This can have an impact on people who cannot communicate their needs as clearly.

Staff were well trained and received a structured induction to their role. Staff were safely recruited to ensure

they were of good character. People were supported to eat and drink a balanced diet. Professional referrals were made if needed. These referrals had a positive impact on people's well-being.

Staff were caring and kind to people. People were involved with making decisions about their care. Dignity was at the forefront of the service values. The service worked hard to reduce people's loneliness. Free transport, and social activities were arranged for people. Those people that did not wish to go out, were supported with activities in their home. The service supported people's complex communication needs with the use of accessible information.

Rating at last inspection

The last rating for this service was Outstanding (published 15 June 2017).

Why we inspected

This was a planned inspection based on the previous rating.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below

Requires Improvement ●

Is the service effective?

The service was effective.

Details are in our effective findings below

Good ●

Is the service caring?

The service was caring.

Details are in our caring findings below

Good ●

Is the service responsive?

The service was responsive.

Details are in our responsive findings below

Good ●

Is the service well-led?

The service was not always well led.

Details are in our well led findings below

Requires Improvement ●

Workwise Healthcare Limited

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

One inspector completed the office visit. One inspector and an assistant inspector made phone calls to people using the service.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses, flats and specialist housing.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We intended to give the provider 48 hours notice of this inspection. This is because we needed to be sure that the provider or registered manager would be in the office to support the inspection. When we gave notice, we were told that the computer systems were being changed and this would impact on the inspection. We therefore gave the provider one week's notice of our inspection.

What we did before the inspection

The provider was asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used all of this information to plan our inspection.

During the inspection

We visited the office on the 30 January 2020. We reviewed a range of records. This included the relevant part of six people's care records and two staff recruitment files. We considered a variety of records relating to the management of the service, including policies and procedures. We spoke with five staff members and the registered manager in the office.

We phoned people to talk about their experience of the care provided. We spoke to six people who used the service and eight relatives. We also phoned five staff. This meant we spoke to ten staff in total.

After the inspection

We continued to seek clarification from the provider to validate evidence found.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- 'As needed' medicines were not managed safely. Staff did not have clear guidance on the use of 'as needed' medicines. Staff also did not record why 'as needed' medicines were given to people. For example, a prescription described 'one or two puffs as needed' of an inhaler. There was no guidance on how the inhaler should be used, or what impact it should have on the person. When staff had supported the person with the inhaler, they did not record why the inhaler had been used, or whether one or two puffs had been taken. The poor management of 'as needed' medicines, risks medicine not being given as prescribed.
- There was a lack of guidance for where topical creams should be applied and for what purpose. Regular staff were aware of people's needs. However, the lack of guidance risks prescribed creams not being applied as prescribed.
- One relative told us that they felt a person did not receive 'as needed' medicine as regularly with new staff compared to their usual staff. They felt this was due to new staff having less knowledge of the person's medicine and communication needs.
- Medicine records were hand written by staff. We found that some medicine records were not clearly written, for example records included the name of medicine but not the dosage. The registered manager explained that staff entering the property were asked to double check the accuracy of the medicine records. However, there was no evidence that this had occurred.
- The registered manager recognised the above errors and we found no impact on people. The registered manager had sent us evidence that they were changing their processes to improve the safety of medicine administration. We will review this at the next inspection.

Assessing risk, safety monitoring and management

- Staff were not always provided with guidance on how to respond to people's health conditions. For example, people with variable mood, diabetes, and respiratory illnesses did not have clear guidance on how these conditions impacted them or what staff could do to support. The registered manager said they would review people's care records, to ensure guidance was in place.
- Care plans provided clear guidance on how to support people's daily routines safely. For example, staff had clear guidance on how to use mobility equipment and support people to bathe.
- The service had created a sister company called 'Handy Helpers'. This was a handy person scheme, which resolved environmental risks in people's homes for free or a low cost. For example, 'Handy Helpers' were asked to fit a free smoke alarm to someone's property. While they were there, they noted that the person would also benefit from a key safe. So, this was also fitted for free. The involvement of a handy person scheme meant risks in people's homes were managed for people and staff.

Staffing and recruitment

- Checks showed calls were completed in a timely way. However, records showed that some 'missed calls' had occurred. This meant the staff member had not arrived at the person's house and the care visit had been missed. This can put people at risk of being unsafe. The registered manager had investigated these incidents and attributed them to human administrative errors (like staff reading a rota incorrectly). They recognised the high risk associated with a missed care visit, and advised they were working to prevent re-occurrences. These missed care visits were a very small percentage of the overall visits provided to people.
- Staff advised that they generally knew the people that they worked with. However, staff were sometimes sent to work with people that they had not met before. Staff advised that they were given verbal feedback from office staff about the person's needs. This informal introduction, risked staff not fully understanding the person's needs before they met. People reported that these new staff knew them less well than their usual staff.
- There were enough staff to support people safely. Staff told us that they were given enough time to travel between people's houses.
- Staff were safely recruited. For example, the registered manager gathered references from a previous employer to ensure that staff had a good character.

Systems and processes to safeguard people from the risk of abuse

- Staff understood how to keep people safe from the risk of abuse. A staff member said, "We can refer to the Local Authority Safeguarding team or management. Our management respond well, and they will always act on concerns."
- People told us that they felt safe using the service.

Preventing and controlling infection

- Staff told us they were provided with enough personal protective equipment (like gloves and aprons). Spot checks occurred to ensure that safe infection control practices had occurred.
- The service had approached The Office of Environmental Health, to review their policy for food hygiene. They advised they received positive feedback on their food hygiene policy.

Learning lessons when things go wrong

- Incidents were clearly recorded. This allowed causes and impact to be considered.
- Where incidents occurred, investigations were completed by the management team. These investigations highlighted potential areas for improvement. For example, staff identified that a person's relative experienced some confusion. This could impact on the person. They referred to the Local Authority social services for assessment and potential additional support.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance

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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- We found mental capacity assessments had not been fully completed for people who may struggle to make a decision. For example, staff removed a fuse from a person's microwave plug and kept it in a cupboard. The assessment did not follow the principles of the act, as it did not assess their understanding, retention, weighing up and communication of their decision to use a microwave. Due to the recording of capacity assessments we were not assured that the person's consent to this restriction had been assessed. This risks staff completing restrictive practice without the person's consent.
- The staff and registered manager had good knowledge of the mental capacity act. There were policies in place, should a person require assessment and support with decision making. Our concerns were therefore focused on the documentation of people's mental capacity

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Staff had good knowledge of the law governing their work. Staff recognised their role in supporting people safely, and how to refer to other professionals when needed.
- There was basic information about people's oral health care needs and staff had received training in oral health care. The registered manager advised they intend to develop oral health care plans to provide more detail.

Staff support: induction, training, skills and experience

- Staff were given a clear induction to their role. Staff reported that this was good quality and prepared them well for their work.

- Staff had received training on how to support people. Staff fed-back that training was a good quality. A staff member said, "We did role play in resuscitation training. It was really good and the hands-on training helped you learn."

Supporting people to eat and drink enough to maintain a balanced diet

- Staff clearly described how people chose their own meals. If people struggled to make a decision, staff would support them to choose a healthy option.
- Where people were at risk of malnutrition or dehydration, clear records were kept on how much they had eaten or drank. These records were reviewed to ensure enough had been consumed.
- Professionals had been contacted if staff had concerns about eating and drinking. This included GP's and dieticians for weight loss and speech and language therapists for choking risks.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People told us (and records supported) that staff referred to health and social care professionals as needed. We saw a thank-you card, which said staff had convinced a person to go to hospital and the person had later been diagnosed with a life-threatening health condition. The person had thanked staff for persuading them, as they had initially declined hospital admission.
- Where referrals to other professionals had been made. Records showed that this multi-professional working had benefitted people. Records showed that one person's skin damage had improved while with the care agency, and staff had recorded verbal positive feedback from the visiting nurse.
- Staff had also worked with the Local Authority to reduce the amount of care staff that people required. One person had required a hoist and two care staff to move, and with close working with an occupational therapist; this person was now walking with one care staff visiting.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as outstanding. At this inspection this key question has now reduced to good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People's diverse needs were assessed. Care plans guided staff on how to support people's preferences.
- Staff had good knowledge about how to support people's diversity. A staff member said, "[Person] likes to go to church but can't at the moment. So, we sit and talk about their religion instead." People's diversity was assessed before they started with the service.
- People reported being well treated by staff. A person said, "They are all caring." Multiple thank you cards had been received at the service. These credited the caring nature of staff.

Supporting people to express their views and be involved in making decisions about their care

- Staff gave clear examples of how they supported people to make decisions about their care. A staff member described how they supported a person to choose their meals. "We show [Person] the meal packets and they choose which they would like. [Person] wouldn't remember if you listed them. It's important for them to pick it out for themselves."
- Care plans and policies at the service focused on people's choice being the centre of the care provided.
- Records showed that people and relatives were involved with regular care reviews. This meant they could feedback any preferences.

Respecting and promoting people's privacy, dignity and independence

- There was a strong ethos of promoting people's dignity at the service. Staff were asked to write in a 'dignity book' at each office visit, to reflect on how they had supported people's dignity. This could then be discussed in their supervision. We read the book, staff had written about the importance of dignity and gave examples like closing people's curtains.
- A staff member told us, "You've got to think how you would want your mum to be cared for. Dignity is a huge thing here. It is so important."
- The service had developed their own dignity training, our discussions with people, and staff showed that this had been effective in creating positive culture.
- People explained that they were supported to be as independent as possible. A person described their washing routine, "They say shout when you need us. They'll be outside and I can call them in when I want help. So I can wash myself".

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as outstanding. At this inspection this key question has reduced to good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People advised us that they had regular visits from staff, who knew their preferences well. On occasion, a new staff member would cover shifts for annual leave or sickness. These staff had not met the person before supporting their care, so their knowledge of the person's preferences was not as good. People told us that this occasional change, impacted on the quality of care.
- A relative explained, "The usual staff know the niceties. Like how [person] likes their tea. Communication to a new staff member doesn't allow that. So, they don't know the extras." Another relative explained that a person had limited communication, and this could result in new staff miss-interpreting their requests compared to longer term staff.

End of life care and support

- The registered manager advised that when people started with the service, they asked about their end of life wishes. However, we could see no evidence that people had been asked about end of life needs. We identified one person had an end of life diagnosis and there was no evidence that this person had been asked about their preferences. The registered manager explained that the person had been asked but had not wished to discuss. They advised they would resolve this by adding end of life discussion to the pre-assessment paperwork as evidence that the topic had been discussed.
- The service's end of life policy focused on expected deaths from a 'terminal illness'. There was no policy on how to support people who had a sudden deterioration in health and required unexpected end of life care. The registered manager advised they would resolve this and improve their policy.
- The registered manager recognised the impact of death on people's loved ones. The service routinely sent out bereavement cards after the loss of a loved one.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- There was a strong ethos of preventing loneliness at the service. People had been offered free Christmas visits and meals, to ensure that they were not alone on Christmas day.
- People were supported to be involved in the wider community. Free transport was offered to those experiencing loneliness to ensure that they could access the community.
- The service created social gatherings, which gave people an opportunity to meet others. This included pop-up teas, a group picnic, fundraisers and attending the mayor's parade.
- For those people who were not interested in social activities, the service supported their interests. For example, people knitted squares. These were then combined into a large patchwork blanket and gifted to other people at the service who felt cold.

- The service sponsored an owl called Ozzy. The service periodically met people's wishes through an 'ask Ozzy' scheme. For example, a knitting bag was given to a person who requested it

Improving care quality in response to complaints or concerns

- Complaints had been recorded and responded to in line with the complaints policy
- A relative told us, "If I needed to complain, they would listen. I rang them with something small once and it was sorted."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- At the previous inspection, staff had received basic British Sign Language training in order to communicate with people. There were currently no people using the service who would benefit from this method of communication. The registered manager told us that they were still able to support people with hearing needs if needed.
- Five people at the service had a visual impairment. The service had previously received advice from the National Institute of the blind. They had sent these people rota's in a large print format, so they could understand who was coming to visit them.
- One person became very anxious about which staff were coming. Staff explained that the person could not remember staff names and had 're-named' staff with nicknames. The person's rota was therefore completed with these nick-names, so the person could remember who was coming.
- The registered manager had a good knowledge of people's communication needs and followed the accessible information standard to meet these needs.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has reduced to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- We identified some concerns with the recording of information at the service. This included the recording of medicine records, care planning for people's health conditions, recording of end of life care plans and documentation of people's mental capacity.
- We reported our concerns to the registered manager. They have sent evidence that they have begun to amend their processes. We will assess the impact of this at our next inspection.
- We also identified some concerns with the end of life policy. The registered manager has advised they have reviewed this policy to include unexpected deaths. We will assess this at our next inspection.
- Staff felt supported to develop and make suggestions. For example, a staff member had created interview questions based on what their experiences of working. These questions had been included in the interview process.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff and people spoke of a positive culture within the service, where people had good outcomes. For example, people were supported to be as independent as possible. Staff had worked with the Local Authority to reduce people's need for support.
- Policies and care plans guided staff to be kind and person centred.
- The service was driven to give people a good quality of life. Social events were organised, and people were given free transport into the community. The use of a handy person scheme meant people's homes were kept safe.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There is a legal duty for the provider to notify the CQC of events that happen at the service. The provider had met this legal duty.
- The provider clearly displayed their previous rating. It is a legal requirement to do this.
- There was a clear complaints process which had been followed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Questionnaires had been sent to people. If negative comments were returned people were contacted to resolve any concerns. We looked at responses to questionnaires, they were mostly positive.
- Staff had regular meetings and supervision. Meeting notes and staff feedback showed that staff were consulted and encouraged to make suggestions for improving the service.

Continuous learning and improving care

- The management team had a strong desire to have a high-quality service and continue to improve. Any concerns highlighted by the inspection team, were considered and plans put in place promptly to resolve.
- There was a clear auditing the service. In general, this was an effective process, however we identified some concerns which should have been identified prior to the inspection process.
- The senior staff team completed regular spot checks on the quality of staff support. Records were kept and showed that minimal concerns were raised. If concerns were raised, then these were resolved promptly with the staff responsible.

Working in partnership with others

- The service had worked closely with other professionals, to ensure that people had good outcomes. Professional feedback was documented for staff to follow.
- The registered manager felt they provided high quality care but were always keen to improve the quality of the service. They explained how they keep up to date with current practice by communicating with the Local Authority.