Ness M Care Services Ltd

Ness M Care Services

Inspection report

110 Swale Avenue
Peterborough
Cambridgeshire
PE4 7GT

Tel: 01733321367

Date of inspection visit:
24 May 2016

Date of publication:
13 June 2016

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

Ness M Care Services is registered to provide personal care for people who live at home. Both domiciliary care and live-in care is provided to people who live in a number of counties, including Lincolnshire, Cambridgeshire, Buckinghamshire, Nottinghamshire and Norfolk. When we visited there were 14 people who were receiving support and care from the agency.

The inspection took place on 24 May 2016 and was announced and carried out by one inspector.

A registered manager was in post when we inspected and had been registered since 13 September 2013. 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.

People were kept as safe as possible because staff were knowledgeable about reporting any person being placed at the risk of harm. There was a sufficient number of staff employed and recruitment procedures ensured that only suitable staff were employed. Arrangements were in place to ensure that people were protected with the safe management of their medicines.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was acting in accordance with the requirements of the MCA so that people had their rights protected by the law. Assessments were in place to determine if people had the capacity to make decisions in relation to their care. When people were assessed to lack capacity, their care was provided in their best interests. The provider was aware of the procedures to follow should any person require A DoLS application made to the Court of Protection.
Staff were trained and supported to do their job so that people received care that safely met their needs.

People were supported to access a range of health care professionals. Health risk assessments were in place to ensure that people were supported to maintain their health. People were provided with adequate amounts of food and drink to meet their individual likes and nutritional and hydration needs.

People's independence, privacy and dignity were respected. People were supported to maintain contact with their relatives.

People's recreational and social activities that people enjoyed were identified and they were supported to take part in these. People's care records and risk assessments were kept up-to-date and which meant that staff had the guidance in how to meet people's individual needs. A complaints procedure was in place and this was followed by staff this meant that people could be confident that any complaints would be dealt with appropriately.

The provider had quality assurance processes and procedures in place to improve the quality and safety of people's support and care.

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's needs were met by sufficient numbers of care staff.

Recruitment procedures ensured that only suitable care staff were employed to look after people.

People's medicines were managed in a safe way by care staff who were trained and assessed to be competent.

Is the service effective?

Good

The service was effective.

People were looked after by care staff who were trained and supported to do their job.

People's rights were protected as the provider was acting in accordance with the principles of the Mental Capacity Act 2005.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People's rights to privacy, dignity and independence were valued and respected.

Care staff were kind and helpful to people they looked after

People were enabled to choose how they wanted to be looked after.

Is the service responsive?

Good

The service was responsive.

People's individual needs were met.

People were enabled to take part in activities which were

important to them.

The provider responded to people's complaints and this was to the satisfaction of those who had complained.

Is the service well-led?

Good

The service was well-led.

The safety and quality of people's care was monitored and kept under review.

People were enabled to make suggestions and comments about their care.

Care staff received support and guidance from the management team which enabled them to provide people with safe care.

Ness M Care Services

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24 May 2016 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care and live-in care service; we needed to be sure that someone would be in.

Before the inspection we received information from a local contracts and placement monitoring officer. We also looked at all of the information that we had about the home. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law.

During the inspection we spoke with three people who used the service and four relatives via the telephone. We also spoke with the registered manager and five members of care staff.

We looked at three people's care records and records in relation to the management of the service and the management of care staff.

Good

Is the service safe?

Our findings

People told us that they felt safe and gave their reasons for feeling so. One person told us that they felt safe because members of care staff ensured that the security of their home was always maintained. They said that the member of care staff used a coded safe to obtain and return the door key to the entrance of their home. Another person said, "[I definitely] feel safe. The carers [care staff] – I trust them. I feel very safe with the carers [care staff]."

Members of care staff were aware of their roles and responsibilities in keeping people safe from harm. They were trained and were able to demonstrate their knowledge in detecting and recognising signs of people being placed at harm. They were also able to demonstrate the correct reporting procedures in the event of someone being placed at such risk; this included reporting directly to the registered manager or to local safeguarding authorities. One member of care staff described the signs of someone being harmed and said, "The person could be withdrawn, or be angry." Another member of care staff added, "The person could have [unexplained] red marks or have weight loss." One person said that they were aware of the local authority's telephone number if they needed to raise any safeguarding concerns. They added, "I feel safe because I am very much in control."

Members of care staff also told us that there was enough staff to look after people. People also said that there was enough care staff to look after them. One person said, "They [care staff] arrive on time. We've never had a missed call yet." One relative told us that their family member required two members of care to support their relative's moving and handling needs; this was "always" carried out by two members of care staff. We heard two members of care staff arrive together to a person's home, when we were speaking with their relative. The time of the call and numbers of staff required were in line with the person's planned care.

The registered manager told us that they carried out assessments to determine people's care needs and matched these against the required staffing numbers. They also told us that this was kept under review. One person told us that when they first started to have the care, this was "intensive"; care staff visited them four times each day to provide them with their planned care. However, due their changed needs and improved health, this number of daily calls was now reduced to one call each day.

Recruitment procedures were in place to assess the suitability of prospective members of care staff. One member of care staff explained that they had completed an application form; had proof of their identity; two written references and a satisfactory police check, before they started their employment. Another member of care staff said, "[I produced] my passport; filled an application form in; had a DBS [Disclosure and Barring Service – police check]. I had a face-to-face interview. These were all before I started because they [the provider] wanted them all in place."

Risk assessments were carried out and people were aware of the management of risks to keep them safe. One person said that they felt safe from the risk of falling and explained why: they said, "I feel perfectly safe because if I stumble, staff are always there." Another person told us about their risk of developing pressure ulcers and how they were involved in managing this risk: they said, "They [care staff] check my skin and if

there are any concerns, we have a series of strategies which we do together." One member of care staff told us how they supported the person to manage their risk of developing pressure ulcers; this was by means of repositioning the person and use of pressure-relieving equipment. They said, "We turn [reposition] [name of person] four to five times each day and I check their skin everywhere. I also check the pressure [pressure-relieving] mattress and cushion [to ascertain their working condition]."

Accidents and incidents were recorded and an example of this was seen. The incident recorded action taken to effectively improve the healing of one person's skin condition following their discharge from hospital.

People's other risks were assessed and managed which included risks associated with eating and drinking and transferring. One relative told us that members of care staff ensured that their family member's risk of choking was reduced with the provision of thickened drinks and soft, moistened food. One person told us that they needed assistance with transferring by means of a hoist and said that the staff were safe and competent when they carried out this procedure. One relative also told us that the staff safely supported their family member when they helped to transfer them from their bed to the chair with the aid of a hoist. Members of care staff told us that they were trained in moving and handling. They also said that their moving and handling competencies were checked when senior staff members observed them at work during 'spot checks'.

The registered manager told us that before any person started their care, there was a system in place to carry out risk assessments of the safety of the premises of people's homes. One relative confirmed this risk assessment took place and was carried out "two days before" their family member was discharged from hospital to return home.

People's independence with managing their prescribed medicines was maintained or their relatives assisted with this care. However, when this was not possible, members of trained care staff helped them to take their prescribed medicines. One person said, "They [care staff] take it [prescribed medicine] from the packets and they give them to me. I swallow them very easily and they [staff] record everything that I have taken." People's medicines administration records showed that care staff supported people to take their medicines as prescribed. One relative said, "I always check 'the book' and I can see that [family member] has had their medicines." One member of care staff said, "Most people take their medicines themselves. We only assist them [if they need it] and check that they have taken them."

Members of care staff told us that they had attended training in management of people's medicines and that this training was refreshed each year. They also told us that they were assessed to be competent with this aspect of their role and staff records showed that this was the case.

Good

Is the service effective?

Our findings

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. At the time of our inspection assessments were in place to determine if people had mental capacity to make decisions about their care. The registered manager was aware of the process to follow should any person require Deprivation of Liberty Safeguard [DoLS] applications to be made to the Court of Protection. This process would include the registered manager's involvement with both health and social care professionals to determine the action needed to be taken and by whom.

Members of care staff said that they had training in the application of the MCA and had an understanding of this. One member of care staff said, "People have different levels of mental capacity. If they don't have it [mental capacity] we do it [provide care] in the person's best interest." One relative told us that they were involved in supporting their family member in making decisions about their care, which included decisions about their personal care. The registered manager advised us that decisions about people's end-of-life care and treatment included medical practitioners and people and their relatives in this decision-making process.

Members of care staff told us that when they first started their employment they had induction training, which included both practical and theoretical training. The practical-based induction training included new members of care watching more experienced care staff at work before, gradually, applying their learning into practice. One member of care staff said, "I shadowed [watched] somebody [member of care staff] who was more experienced. I was looking at what they were doing. After a few days I worked with one of them [member of experienced care staff] while another one of them looked at what I was doing. This was to check that what I was doing was what I should be doing."

The range of training topics, which care staff attended, included moving and handling; food hygiene; infection control and caring for people with diabetes. One member of care staff told us that they had attended training in the management of people's diabetes and this had raised their awareness in detecting the signs and symptoms of a person with unstable levels of blood sugars. Training was also provided to meet people's individual health needs. The registered manager said, "Training is based on people's care needs and I have to check the staff competency of that training." They also provided an example of accessing training from an outside source; this was about supporting individual people, who were unable to eat and drink by mouth, and who needed their food and drink provided by alternative methods.

Staff training records demonstrated that staff had attended training in dementia awareness; supporting people who had diabetes, a spinal cord injury and epilepsy. One person told us that they were confident in the ability of staff to understand their complex condition associated with their central nervous system [CNS]

and were able to recognise the signs and symptoms of when they became unwell. This, they said, was due to the training staff had received regarding their CNS and had gained an understanding in the management of their condition. They added, "I have a carer with me - who knows what they are doing - when I go out as I can become very unwell at any time." One relative told us that staff communicated with their family member, who was living with dementia, in a way that helped them remain settled. They said, "They [staff] talk with [family member] all the time to keep [family member] calm. They explain everything to [family member]."

Staff said that the felt supported and this support was by a range of methods. One member of care staff said, "They [registered manager] look after us and make sure we have everything we need." The prime level of support was by mobile 'phone text messaging or phone calls to the agency's office. There was a system in place for care staff to contact the registered manager at least once per week. This was to keep them up-dated about people's care but enabled the members of care staff to discuss any work-related and well-being matters with the registered manager. The registered manager said, "Most of my communication with staff is via a newsletter or by mobile 'phone. Care staff must report in at least once per week or as often as they need to discuss people's care needs and the support needs they have." We heard the registered manager receive one of these calls from a member of care staff and this provided the registered manager with the opportunity to ask the staff member how they were. Another method of staff supervision was during 'spot checks' when staff were observed at work. The registered manager told us that 'spot checks' provided feedback for care staff to ensure that they followed correct working practices and procedures; this included, for example, those practices and procedures associated with management of people's prescribed medicines.

People were satisfied with how staff supported them to eat and drink. One person said, "They [care staff] prepare my breakfast. If I wanted a cooked breakfast, they would do it for me." They also told us that members of care staff ensured that they always had a drink left in their reach. Another person said, "I have a certain diet to manage my health. Everyone [care staff] deals with it and are very helpful in managing my diet." One relative told us that they were satisfied with how member of care staff helped their family member to eat and drink and said that they always had enough to keep them healthy. People who were assessed to be at risk of dehydration or being under-nourished had their food and drink intake monitored. Records, of one of the people assessed to be at such risk, showed that the person was taking adequate amounts of food and drink each day to maintain their nutritional health.

People and relatives told us that staff supported them in gaining access to health care professionals, when this was needed. The registered manager was aware of people's health conditions and any changes were reported and recorded on people's individual records. Changes included, for example, in people's skin condition and breathing. People's records showed the registered manager had made contact with the person's GP and community nurse. One person told us that they had a hospital acquired pressure ulcer which, due to the shared care between the agency and community nursing service, their pressure ulcer was now healed.

People and their relatives told us how they gained benefits from the care provided by the agency. One person said that the care had helped them manage their depression by reducing their social isolation. One relative said, "The care has made my life a lot easier and less stressful for me." They also told us that the care had enabled them to remain the main carer for their relative and this had helped them to remain living together in their own home.

Good

Is the service caring?

Our findings

We received a number of positive comments about how people were looked after. One person said, "I have a very good relationship with the staff. There's no imbalance of power." One relative said, "[Family member] really gets on well with the staff." The agency had received 'thank you' cards and letters. One of these read, "I would like to thank all of your staff for the excellent care they gave to [family member] and me. They were warm, caring and respectful on every visit… They certainly helped my days with their kindness and cheerfulness. My [family member] …remarked to me many times 'don't they [care staff] look after us well'."

People told us that they liked having the same core of care staff as this had helped them build up a relationship with them. However, some of the people and relatives told us that, due to changes in the availability of care staff, this was not always possible. The registered manager told us that they provided short-term care for people wishing to have their end-of-life care at home. This demand had, sometimes, meant that members of care staff worked elsewhere to meet this short-term care. The registered manager added that they aimed to provide people with consistent care as much as they were able to. They recognised the advantage of consistent care and the subsequent forging of therapeutic relationships. One 'thank you' card read, "I appreciate the difficulties of the care industry and I am grateful that the agency has tried hard to find compatible carers."

People and their relatives were involved in planning the care and making choices and decisions about this. One person told us that they had asked for a change of time for when they wanted their care and said that their request was respected. One relative told us that they asked for their family member to have a shower each day, as this had helped improve their mood, and their request, too, was respected. People and relatives were also aware of the planned care, which included the time of the call visits and the type of care provided during these times. One relative told us that their family member's lunch time call was to help their family member with their continence needs. The person's care records showed that members of care staff followed the care plan as agreed by all parties.

People were supported to maintain contact with their relatives and the care provided also enabled people to remain living at home and be part of the community.

People's independence was maintained and promoted. One person told us that the care had increased their level of confidence; this had directly increased their level of independence and decreased the number of care visits as a result. People's independence with eating, drinking, managing their own prescribed medicines and making appointments with GPs was also respected.

Good

Is the service responsive?

Our findings

People told us that they were satisfied how their health needs were met. This included, for example, their mobility and continence needs. One relative also told us that they were satisfied with how members of care staff supported their family member with both their moving and handling and continence needs. In addition to this, the care provided responded to people's relatives' needs and helped them to remain as the main carer for their family member. One relative said, "I would find it very difficult to care [for my family member] without them [care staff]." The registered manager said, "Sometimes it [the care] is looking after the relatives as they need a bit of support and care in dealing with that of being the main carer."

People told us that the care staff knew them as a person and this level of knowledge increased with a continuity of care staff. One person told us that they had the same staff to look after them. They said, "The staff are absolutely brilliant. They are the right people for the right job. You can have a good laugh and joke with them." One relative said, "[Family member] has dementia. [Continuity of care] keeps [family member] settled."

Care records demonstrated that the registered manager assessed people's needs before they were to receive their care. The assessments detailed, for example, the person's medical history; prescribed medicines; personal care needs and identified health and safety risks, such as risk of behaviours that challenge. One relative told us that they were part of this assessment process before their family member was discharged from hospital to return home. They said, "The only way [family member] could come home was to have four calls a day." They told us that their views and needs were taken into account during this stage of the assessment process.

People's care records were kept-up-to-date with notes of changes in people's care and conditions and the actions taken by whom and when. This included, for example, when a person required antibiotic treatment for a chest infection. One person told us how their care records were maintained and said, "They [staff] record everything, every day." One relative said, "The staff complete the care records after every visit."

People's relatives told us that they were invited to reviews of their family members' care. The reviews were carried out by GPs and authorities who were responsible for the payment of people's care at home. Records showed that the reviews enabled all parties to review how the planned care was meeting the person's assessed needs. Changes were made, which included, for example, the introduction of clear guidelines for staff; this was in relation to their legal responsibilities when looking after people who had a history of substance mis-use.

The care provided helped people to take part in activities that were meaningful to them. One person's record demonstrated that they liked listening to music: their relative and registered manager told us that care staff supported them with this. One person told us that care staff took them out to go shopping and to eat out. One member of care staff added that the person also liked to visit a park to sit "and watch the birds."

People were aware of the provider's complaints policy and told us that they had used this to make changes to how they were being looked after. One person told us that they had raised a complaint and said that this was "managed very effectively." They said that they were satisfied with the action taken on the same day that they had complained. One relative told us that they, too, had raised a complaint and was satisfied with the action taken by the registered manager. The registered manager advised us that information about complaints and concerns was recorded on people's individual records. However, there was no system in place to analyse if there were any emerging trends. The registered manager told us that their investigations into people's individual complaints had shown no emerging trends to analyse.

Good

Is the service well-led?

Our findings

The registered manager was a registered nurse and used her nursing experience in assessing people's complex health needs. She was supported by an office manager and was in the process of recruiting another member of staff to support her role in managing and supervising care staff.

People told us that they knew who the registered manager was and how to contact her, or the office manager, if needed. An out-of-hours on-call system was available for members of care staff, people and relatives to use.

People were provided with opportunities to make suggestions and comments in questionnaires. Positive comments were entered in the questionnaires about how they were looked after. Members of care staff also were provided with opportunities to make suggestions to improve the management of the agency. The registered manager told us that the main emerging theme was the suggestion for continuity of care staff and care staff to know when they were expected to work. However, the registered manager explained that, due to the changing demands of their business, this was an area identified for improvement but difficult to achieve. Nevertheless, the registered manager aimed to provide people with consistent care, based on their suggestions, as reasonable and practicable as possible.

Quality assurance systems were in place to monitor the safety and standard of people's care. We heard the registered manager speaking to staff on the telephone and found that they were asking members of care staff about people's health conditions and any changes to these. This was part of a reviewing and monitoring system to assess that people's care and medical treatment were meeting their needs. The registered manager also took the opportunity to ask the members of care staff about their health and well-being.

Other quality assurance systems were in place when, during 'spot checks', members of care staff were observed at work, often by the registered manager. One person said that the 'spot checks' provided them with the opportunity to feedback to the registered manager their views about their care. They told us that they were satisfied with how they were looked after and no changes were required to their planned care.

One member of care staff described their experience of being observed during a 'spot check.' They said that these were often unannounced and only announced if the person, who they were looking after, may not always be at home. One relative said that members of care staff were 'spot checked' and, "We just had one about two weeks ago." Records of the 'spot checks' demonstrated that people were being looked after by care staff who had up-to-date training to meet people's individual needs, such as needs associated with an impaired CNS. The 'spot check' records also showed that people's privacy, dignity, choice and independence were valued. Audits were also carried out to ensure that care staff maintained accurate records and that people's assessed risks were safely managed. These included health risks associated with lack of hydration, under nourishment and safety risks attributable to moving and handling.

The registered manager was aware of their legal responsibilities in submitting required notifications to us.

We made them aware of the requirement to submit notifications should any person have an authorised DoLS in place.

Some of the people had their care shared by the agency with other, external agencies. The registered manager had introduced a record to aid effective communication between all agencies. The registered manager told us that this ensured people received continuity of care, due to this and said that it "worked well."

Members of care staff were aware of the whistle blowing policy and when this was to be used. One member of care staff said, "I would report it [concern] straight to the office [registered manager]. It [whistle blowing policy] protects you from losing your job." Another member of care staff expanded on this and said, "Whistle blowing is when you see something is not right and you report it to the office [registered manager] but it is also about not telling anyone else." They clarified this and told us that the whistle blowing policy was about maintaining confidentiality in respect of the identity of all parties involved.