Change Social Care Solutions Ltd

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service:

Change Social Care Solutions is a domiciliary care agency which provides care to people in their own homes.
There were 15 people using the service at the time of our inspection. However, 10 people did not receive support with personal care. CQC does not regulate this part of the service. Therefore, our inspection only focussed on the five people receiving personal care. The five people receiving personal care were older adults (over 65 years of age). They all lived within the London Borough of Brent and had their service commissioned by the local authority. The service covered a range of areas including prompting with medicines, personal care, weekly shopping, housework and laundry.

People's experience of using this service:

People felt safe with the care they received from care workers. There were effective systems and processes to minimise risks to people. People were protected from abuse and avoidable harm.

People received personalised care and support specific to their needs and preferences. There was good evidence that people's care, treatment and support promoted a good quality of life.

People were treated with dignity and respect. We saw evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People had choice and control over their care. Their care plans gave a comprehensive account of their needs. Their preferences and dislikes were outlined, with corresponding sets of instructions for meeting each identified need.

The service was well-led. A range of quality assurance systems had been used continuously to drive improvement. There were effective arrangements in place for monitoring, investigating and learning from events.

Rating at last inspection:

This was the service's first inspection since registering with CQC.

Why we inspected:

This was a planned scheduled inspection.

Follow up:

Going forward we will continue to monitor this service and plan to inspect in line with our inspection schedule for those services rated Good.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 safe.	**Good**
Is the service effective? The service was effective.	**Good**
Is the service caring? The service was caring.	**Good**
Is the service responsive? The service was responsive.	**Good**
Is the service well-led? The service was well-led.	**Good**

Change Social Care Solutions

Detailed findings

Background to this 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

Our inspection was completed by one adult social care inspector.

Service and service type:

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 gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

What we did:

• Our inspection was informed by evidence we already held about the service.
• We asked the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
• We spoke with two people and relatives of the other three people using the service..

• We spoke with the service director, registered manager and three care workers.
• We reviewed five people's care records, seven personnel files of care workers, audits and other records about the management of the service.
• We requested additional evidence to be sent to us after our inspection. This was received, and the information was used as part of our inspection.

Good

Is the service safe?

Our findings

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

At this inspection people told us that they felt safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse:

• People felt safe with the care they received from care workers. One person told us, "I feel completely safe." Three relatives we spoke with told us their loved ones were safe and well looked after.
• There were safeguarding systems and processes to support care workers to understand their role and responsibilities to protect people from avoidable harm. A safeguarding policy was in place. Care workers had access to this and had received safeguarding training.
• Care workers were aware they could raise concerns through relevant policies and were confident any concerns raised would be dealt with effectively to make sure people were protected. They were also aware they could report allegations of abuse to the local authority safeguarding team and the Commission.

Assessing risk, safety monitoring and management:

• We found the service to be providing safe care. Risks to people had been identified, assessed and reviewed. Care plans included risk assessments covering a range of areas, including falls, and behaviours that may challenge the service.
• Care workers could describe the risks to people and actions they took to keep people safe. For example, one person was at risk of developing pressure ulcers and their care plan contained a set of instructions to reduce the risk, including regular repositioning at each visit.
• Equally, care workers were conscious of the triggers to specific behaviours that may challenge the service and were aware of the least restrictive way to make sure people were safe. For example, there were instructions on how to back off to allow people space to calm down, without resorting to physical interventions.
• Environmental safety was also considered. This covered a range of areas, including trip hazards, fire safety, and moving and handling. The registered manager was aware they could contact relatives, landlords or alert local authorities for any maintenance work.
• The risk assessments were reviewed regularly, which ensured people's safety and wellbeing were monitored and managed appropriately.

Staffing and recruitment:

• Care workers had been recruited safely. They underwent appropriate recruitment checks before commencing employment. Pre-employment checks had been carried out. Checks included, at least two references, proof of identity and Disclosure and Barring checks (DBS). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

• We spoke with people about staffing levels. They told us, "I have regular care staff who attend to my needs." Relatives also felt the service had sufficient staff to attend to people's needs. An electronic scheduling and monitoring system was in place to manage staff shifts. The system also enabled the service to monitor staff punctuality.
• The service had an on-call system to make sure care workers were supported outside the office hours. Care workers were aware of who to contact outside of normal working hours should emergencies arise.

Using medicines safely:

• There were systems in place to ensure proper and safe use of medicines. There was a medicines policy which provided guidance in line with national guidance from the National Institute for Clinical Excellence (NICE).
• Care workers were suitably trained to administer prescribed medicines. There was evidence they had been trained and assessed as competent to support people to take their medicines.
• Medicine administration records (MAR) were completed appropriately and regularly audited.
• People told us their medicines were safely managed. One person told us, "I receive my medicines on time." This was a view that was held by all people who spoke with who received support with their medicines.

Preventing and controlling infection:

• People were protected from the risks associated with poor infection control. There was an infection control policy in place. Audits had been carried out as required.
• Care workers were trained in infection prevention and control. They had access to personal protective equipment, including disposable gloves and aprons, which were kept at the office.

Learning lessons when things go wrong:

• There was a system for managing accidents and incidents to reduce the risk of them reoccurring. All accidents and incidents were investigated and learning outcomes were shared with all concerned.
• The service had clear records to show how they had managed incidents, including following up on the outcomes of investigations.
• There was evidence of the service was working with the other agencies, where necessary, when investigations took place.

Good

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

People's outcomes were consistently good, and people's feedback confirmed this.

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

• People's needs had been assessed before they started to use the service. Assessments covered areas such as background information, mental capacity, risks, medicines, current situation, including medical and social needs.
• We looked at five care plans and all gave a comprehensive account of people's needs and actions required to support them.
• People gave us positive feedback about how the service was meeting their needs. One person told us, "Staff support me to ensure my health needs are all being met." This view was shared by people and their relatives.
• Information from people's visit notes also showed that people were receiving support as described in their care plans. We saw that these records were verified during audits carried out by the service. This ensured care was delivered as described.

Staff support: induction, training, skills and experience:

• Care workers were trained, skilled and experienced in their role. A person receiving care told us, "Staff are confident in their role. They are aware of what I require when they visit me." This was a general view held by relatives and other people we spoke with.
• Care workers had completed essential training, which covered a range of areas, including, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), safeguarding and health and safety.
• Care workers had also completed an induction programme based on the Care Certificate framework. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.
• Care workers confirmed they had shadowed experienced members of staff until they felt confident to provide care on their own.
• All care workers received regular supervision and appraisals. We also saw evidence that regular spot checks of competence and practice were undertaken.

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

• People's rights were protected because the service ensured that the requirements of the Mental Capacity Act 2005 (MCA) were met.

• The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
• People who were unable to make decisions about their care had been assessed in line with the MCA 2005. People told us that they were supported to make decisions about their day to day lives. We examined people's records, which confirmed that decisions had been made in their best interests and by whom.
• Where possible, people, or their next of kin, had signed the care records to show that they had consented to their planned care, and terms and conditions of using the service.

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

• People were supported to eat and drink to maintain a balanced diet. There was a nutrition and hydration policy to provide guidance to care workers on meeting the dietary needs of people.
• The service assessed people's nutritional needs and supported them to have a balanced diet. People's care plans contained detailed information about food and drink.
• Even though care workers were not always required to prepare people's meals, we saw that where required, they supported people to prepare and eat their meals. Where relevant, there were reminders in people's care plans for care workers to always leave drinks with easy reach.

Staff working with other agencies and supporting people to access healthcare services and support:

• The service worked with other agencies to provide consistent and timely care. For example, people were supported to access the healthcare services they needed. Care workers accompanied them to hospitals and appointments with GPs.
• The service liaised directly with the local authority, legal practices representing some people, hospitals and other healthcare professionals. One person told us, "My appointments have all been arranged on time and care staff have been able to accompany me."

Good

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.

People were supported and treated with dignity and respect; and involved as partners in their care.

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

• The service had an up to date policy on equality and diversity. Care workers had received training on equality and diversity, as part of their induction.
• People's care plans recorded key information about their care. This included people's gender, interests, culture, religion and language. We saw examples where care workers were matched according to language and culture.
• Care workers were aware of people's backgrounds and were respectful of people's religions and cultures. For example, people were supported with their religious observances, including visits to church and mosque, where this was required
• The service had a same-gender care policy. This made provisions for people who preferred to receive care from same gender staff to have their needs met. We saw that people had been asked if they had any preferences for male or female care workers. Where a preference had been identified this was respected.

Respecting and promoting people's privacy, dignity and independence:

• We asked people if care workers respected their privacy and dignity and they told us, "Care staff show me respect. They always ring the bell before they enter my home."
• Care workers told us that they closed doors and drew curtains when providing personal care. Care workers recognised when people required personal space to ensure people's privacy was promoted.
• The service recognised people's rights to confidentiality. Care records were stored securely in locked cabinets in the office and, electronically. The service had updated its confidentiality policies to comply with the General Data Protection Regulation (GDPR) law.
• Care workers supported people to maintain their independence. Care workers were aware of people's abilities to undertake tasks related to their daily living, such as bathing or food preparation. This ensured they could give the right support to people to be engaged as fully as they could. One person told us, "I am provided with time to carry out the roles that I can do for myself."

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

• People told us they had been fully consulted about their care. Care plans contained information about people's preferences and identified how they would like their care and support to be delivered.
• People's care plans contained a 'consent to care and treatment' form. This was continuously reviewed to ensure consent was obtained prior to any proposed care and treatment.
• The service carried out regular surveys to ask people of their opinion regarding the service. Feedback from

recent surveys were positive.

Good

Is the service responsive?

Our findings

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

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

• People told us that they received personalised care that met their needs. People told us, "My care is very personalised to my needs." A relative told us "My loved one receives care that meets their needs."
• We looked at five care files. Each gave a comprehensive account of people's needs. Their preferences and dislikes were outlined, with corresponding set of instructions for meeting each identified need.
• Care plans were reviewed on a frequent basis to make sure they remained up to date. Reviews also took place if care needs changed before the next scheduled review was due.
• We saw good examples of person-centred care. In one example, the service provided care workers at short notice to facilitate the discharge of one person from a hospital. In another example, we saw that a person receiving care was supported to cope with the transition of their loved one moving to a care home, having lived together for many years.

Communication:

• All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements.
• At the time of the inspection the service did not have people who required support with communication. However, the registered manager was aware of the requirements of the AIS. She told us that the service would ensure information was provided to people in a way they could understand.

End of life care:

• None of the people using the service required support with end of life care. However, the service had a policy for end of life care.

Improving care quality in response to complaints or concerns:

• The service had a complaints procedure which people and their relatives were aware of. The procedure explained the process for reporting a complaint.
• People told us they could discuss any concerns they had with the registered manager and were confident any issues raised would be dealt with.
• At the time of this inspection, the service had not received any complaint.

Good

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.

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:

• People received individualised support that met their needs. People told us they were involved in all aspects of their care and support and that care workers worked with them to determine the support they needed.
• People's care plans included information about their life histories, their likes and dislikes and detailed information on how they should be cared for and supported.
• Care workers were knowledgeable about people's needs. They knew people well and could describe to us how people liked to be supported.
• The leadership complied with the duty of candour. This is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. The registered manager was aware of the need to keep the Commission informed of significant events.

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

• There were clear management structures in place. The registered manager was supported by the provider.
• Care workers spoken with were fully aware of the roles and responsibilities of the registered manager and their lines of accountability.
• The registered manager had capacity and skills to deliver good quality care. She is a registered social worker, a best interest assessor and a health and safety advisor. She is also the Chair for registered manager forum in Brent, that is organised by Skills for Care.
• We found the registered manager to be passionate and dedicated to providing quality care. She was knowledgeable about issues and priorities relating to the quality of care.
• There was an open culture within the service. The service held regular staff meetings to enable staff to share ideas and discuss good practice when working with people. Care workers were routinely asked for their views about the service and any concerns they may have. The service also sought feedback from people and their relatives, which it acted on.
• People and their relatives thought the service was well-led. One person wrote to us stating, '[the owner of the service] is an exceptional manager who has, as far as I'm concerned, far exceed her role by advocating and supporting my [relative] on a day to day basis'. This view was expressed by all people spoken with.

Continuous learning and improving care:

• There were a range of quality assurance systems and processes in place to drive improvement. These included monitoring of accidents and incidents, regular audits, staff supervision and spot checks.
• Staff had received regular supervision from senior staff which included a 'spot check' where the registered manager observed them providing care to people and assessed areas such as their punctuality, the quality of logs, medicines and how they worked with the person.

Working in partnership with others:

• The service worked together and with other health and social care professionals to understand and meet people's needs and to assess and plan ongoing care and support.
• We saw that Information was shared between services, with people's consent. Meetings took place with other health care professionals on a regular basis when care plans were routinely reviewed and updated.