Ann Mason Care

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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

The inspection took place on 15 and 20 March 2018 and was announced. The previous inspection took place on 31 October and 2 November 2016 and we had rated the service as requires improvement. At this inspection we found a good quality service that had delivered on assurances made to improve the safety and well led sections in the last report.

Ann Mason Care is a domiciliary care agency, which provides personal care and support to people in their homes. People receive a range of different support in their own homes, from daily visits, to live-in care. At the time of inspection there were 51 people receiving a service. The locations covered for daily visits included south Suffolk and North Essex. Including but not limited to Maningtree, Colchester central, Stoke by Nayland, Dedham and East Bergholt. The live in care was provided to people mainly in Suffolk and Essex, but also other nearby counties including Wiltshire.

There was a clear management structure in place. As a registered person, the provider has legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were systems in place to monitor the quality of the service and a computer system was able to monitor and run reports to ensure that systems ran smoothly. People's views were sought and acted upon. Staff felt supported and the provider promoted an open culture which welcomed constructive criticism. Feedback about this service from people and staff was highly positive. Both parties felt supported by an organisation that promoted good values of care.

People were supported by staff to stay safe in their homes. Recruitment was robust and safe. Staff assisted people to take their medicines as prescribed. Checks helped ensure people were receiving the medicines they needed. Risk assessments ensured staff were aware of how to support people to remain safe in their homes. There were sufficient staff to meet people's needs and to manage risk safely.

Staff were well supported and spoke highly of the service and the manager. Training ensured staff developed the necessary skills meet people's specific needs. People were given choices about the care they received. Where people did not have capacity there was understanding of how to make decisions which were in their best interest. People were supported to consume food and drink of their choice. Staff worked

well with health care professionals to help people to maintain good health.

Staff knew people well and developed positive relationships with them and their families. Staff treated people with respect and dignity. Care plans were in place which outlined people's needs and there were systems to ensure people's needs were reviewed as required. People received a detailed response when they made a complaint and their concerns were dealt with effectively.

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 had detailed care plans, which included an assessment of risk. These contained sufficient detail to inform staff of risk factors and action they should take.

People were supported by trained staff who knew what action to take if they suspected abuse was taking place.

There were enough staff to cover calls and ensure people received a reliable service. Safe recruitment systems were in place.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had received training and supervision to carry out their roles.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

Staff protected people from the risk of poor nutrition and dehydration.

People had their health needs met and were referred to healthcare professionals promptly when needed.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who knew them well.

People were involved in all aspects of their care and in their care

plans.

People were treated with dignity and respect by staff who communicated well.

People were encouraged to express their views and to make choices.

Is the service responsive?

Good

The service was responsive.

Support was flexible and responded to individual needs.

Regularly reviewed care plans provided detailed information to staff on people's care needs and how they wished to be supported.

The manager logged complaints and responded to them in a personalised way.

Is the service well-led?

Good

The service was well led.

The provider had quality monitoring processes to promote the safety and quality of the service.

People who used the service and their relatives were asked for their views to develop the service further.

There was an open, positive and supportive culture at the service and the vision and values of promoting independence were understood and put into practice.

Staff felt well supported.

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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 inspection took place on 15 and 20 March 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to respond to our queries.

The inspection team consisted of one inspector.

On the day of the inspection we visited the agency's office and spoke with the owner manager, two staff responsible for co-ordination of both the domiciliary daily care support and the live in care staff. We spoke to the person responsible for staff recruitment and training. We also spoke with five care staff. We visited the home of four people who used the service and met with them and their families and or the staff supporting them on that day. We had also received feedback from our survey of people at the service. We received 14 responses back from people who used the service and 15 back from staff.

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 any improvements they plan to make. We checked the content at inspection was correct. We reviewed information we held about the service including statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. Statutory notifications include information about important events, which the provider is required to send us by law. We used this information to plan the inspection. We also looked at information sent to us from others, including family members and staff.

We looked at seven people's care records and three staff records. We examined information relating to the

management of the service such as health and safety records, personnel and recruitment records, quality monitoring audits and complaints.

Good

Our findings

At the previous inspection dated 31 October and 2 November we had rated this key question as requires improvement. We had highlighted some minor issues related to medicines management and the need to ensure changes implemented were sustainable. At this inspection, we have rated this key question as good.

Most people were independent with their medicines or had a family member manage this for them. Therefore staff did not always need to take responsibility for this element of care. There was a policy and procedure in place to guide staff and they knew how to access this. We examined medicines charts that were being used. Charts in place showed that staff had administered medicines to people as prescribed. Where people had medicine delivered by a patch, staff were following guidance and rotating the site of administration. We saw that where required people had medicines care plans in place to guide staff based upon the individuals circumstances. Daily notes recorded when and where creams where applied. Staff had received medication training so that they would be able to administer medicines if this were needed. We observed medicines training being completed for two new staff during our office visit. Staff confirmed that they did not give any medicines until they received the appropriate training. They also confirmed that they had their competence checked. The manager explained that these competencies checked not just oral administration, but other routes of medicine administered such as eye drops, patches and creams.

People told us they felt safe with the staff who supported them, When asked a person told us "Yes I do trust staff. I feel very safe with them." Another person said, "Yes I feel safe. I would give my carer 100%. I'm very spoilt and feel cared for."

Staff had attended training in safeguarding and were able to confirm that they would report any concerns immediately to protect people. Staff were able to give us examples of abuse which they would look out for. For example, a member of staff told us they had reported a matter that concerned them and this was dealt with in line with expectations and known procedures. They told us, "If that was my grandma I would want it known and them to be protected." Staff also told us that there were clear procedures in place when they handled people's monies that ensured people were protected. This included evidence that accounted for any money spent.

We explored an example where the manager had raised a safeguard with the local authority when they were concerned about a person's safety and found this had been appropriately managed. These examples showed us that actions would be taken to safeguard people using the service.

Detailed risk assessments were carried out and comprehensive plans were in place for each area where people were found to be at risk. The initial assessment document covered risks to the person and their environment. In addition there was an assessment that related to fire prevention and how properties were to be accessed, parking and lighting. The assessments were to keep both people and staff safe. The detail in assessments was helpful to guide staff. For example, the mobility risk assessment stated how many staff were required to safely support the person, what they were required to do, listed the equipment to be used and where this was located within each person home. We could see from the staff meeting minutes that changes to risk assessments were discussed and actions taken in terms of ensuring equipment was safe to use. One person told us, "Their communication is so good. If anything changes with me, then they all know about it. They speak to each other and are up to date,"

During the severe weather such as the recent snow we saw that visits to people were prioritised. A risk assessment had been completed to ensure those most as risk received the visits required. The assessment considered those people living with dementia, people living on their own, medicines required to be administered and people who had catheters. This meant that no one in need had missed a visit. There were others who had. One person told us that they had been informed and that they were safe because their relative was with them.

We discussed lone working safety with a care coordinator and they were able to reassure us that risk assessments were in place and actions taken. One key element to this was the App used by staff when they signed in and out of their call visits. If a staff member was later than 10 minutes arriving at an agreed call then the system would automatically send an email to the care coordinator for them to investigate the staff member's whereabouts, this also allowed people to be notified of any late calls.

There was sufficient staff to support people to stay safe. The majority of staff had contracted hours and had regular rounds they completed. There was a small number of staff approximately three or four who were on zero hours contract. The contract along with mileage paid, and time paid to travel ensured that the staff retention was good, thus ensuring people had the same regular carers available to them. People told us that they had the same small group of staff to support them and knew them well. Staff said they had enough time to carry out care visits but if they needed more time they would tell the office and felt they would be listened to. Staff told us where possible they saw the same people. One member of staff told us, "People tend to have a small group of carers."

The feedback we received confirmed the service aimed for continuity when allocating staff rotas. Most people stated that although they had different staff, they were supported by a group of staff with whom they had familiarity. For example, one relative confirmed they had a regular group of staff and said, "I like a roster. I never mind who comes. I just like to know the planned time."

There was a clear system to coordinate breaks for live-in carers, which helped ensure they were not too tired or isolated to carry out their work safely. Where a person was assessed as not being able to be left safely for two hours we saw that cover was arranged. Live in carers were rotated based upon individual agreements. When there was a handover form one staff to another this was comprehensive with staff spending on average one and a half days together to understand people's needs before the live in care was handed over to a different carer.

People gave particularly positive feedback about staff's attention to cleanliness around the house and when providing support. We were told by people that staff always carried gloves and other protective equipment and would wear these when required. A staff member told us, "All staff carry their own PPE (personal protective equipment)." We saw that staff had access to gloves and aprons within the office and that it was

used when supporting people. In addition some people chose to have staff remove their shoes upon entering their home or have them wears blue plastic covers. This ensured people's homes remained as clean as could be.

The service had a system in place for reviewing and investigating incidents and near misses. Staff understood the importance of recording significant incidents and of informing the provider so that they had accurate oversight of the service. An example was that staff had reported a broken piece of equipment within a person's home. Measures were then taken to make it safe for the person and staff.

Good

Our findings

People's needs and choices were appropriately assessed in line with current thinking. The standard assessment form used by the agency did include reference to current legislation. This was completed before people started to use the service. For one person staff had got to know the person in their previous location and supported them over two days before they returned home. This ensured they understood the person's needs and choices. Health professionals were consulted to ensure changes that were requested were appropriate and the best outcomes for the individual. A relative told us that an assessment was completed and followed up upon. "They looked at his needs, all the medical problems and made sure we had the equipment to continue with the right care."

Staff had skill, knowledge and experience to deliver care to people. When asked one person said, "Yes staff do have the correct skills." A relative said, "Staff do understand my relatives condition."

We spoke to staff about the training and support they received and found that they felt appropriately trained and well supported. A person specifically employed for delivering training had ensured staff had the skills and knowledge to do their job. The trainer had up to date qualifications to deliver the training required by staff such as moving and handling and first aid as well as a teaching qualification. More specialist training to meet people's needs had been accessed such as dementia training and Parkinson's. One staff member said that for a person who had a clinical need in their care, staff had the training to understand when they needed to refer to medical professionals for intervention. One staff member said, "The training has been improved over the years. I feel confident and competent to do my job. I'm even been given the opportunity to move on and do management training." Another staff member said, "I have the theory and practical training. I have certificated training. I have the care certificate." The completed PIR told us that 20 staff had completed Skills for Care Common Induction standards or Care Certificate. The PIR also told us that high percentages of staff had received relevant training to perform their roles.

We found that staff had appropriate induction, competency checks and on going monitoring along with regular supervision. Staff told us they felt well supported through the very regular team meetings that took place and well as the visits from the owner or other senior staff. Live in staff received regular [approximately weekly] visits to ensure their wellbeing, and support with any issues that may have arisen. A person with in a live in carer said, "Ann Mason takes care of her staff. She checks up on them once a week. She contacts them to know how they are getting on."

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.

We checked whether the service was working within the principles of the MCA. Staff spoken with were able to talk about the MCA and how they put this in to practice. For example staff understood the need for consent to treatment each time a procedure was completed. They knew what to do if they believed a person may lack capacity to consent. Assessments conducted ensured that the service knew if people had lasting powers of attorney in place for care and welfare and or finances. Where this was the case staff knew this legal status and had involved those named.

The manager had attended training on the MCA and was able to provide us with evidence and relevant information about this. The PIR told us that 30 staff had received training on understanding MCA.

Staff supported people to have enough to eat and drink if this was part of their care package. Staff had received training in basic food hygiene if they handled food. One person who had a live in carer said, "Yes I have all my meals cooked for me and it is what I choose. Sometimes I like to go out to eat."

There were plans in place where a risk assessment indicated that a person might have problems with swallowing. We could see that the appropriate health professionals had been consulted and advice sought on food textures. A different person had a plan for their diabetes and what this meant in terms of food that was better suited for them. If required, food and fluid charts were kept to monitor people's intake so that remedial actions could be taken if needed.

People's care plans included detailed information outlining specific health conditions. One specific health condition required staff to be trained in a technique by hospital staff. The care plan had a protocol in place to guide staff. Staff were clear when they needed to consult a nurse specialist. Staff skills in relation to specific conditions was promoted and valued. We repeatedly found that the agency worked with other professionals to ensure the best possible outcomes for people using the service. This included health professionals such as GP's, speech and language therapists and continence advisers. In addition, there were good working relationships with people within the local authority and the agency ensured they sought advice and training where necessary.

The premises of the agency were extremely good. They were accessible to people of all abilities. Staff had access when needed. Equipment in people's homes had been obtained to ensure their safety and independence. There were good links with occupational therapists to ensure equipment deliveries of equipment such as beds specific to meet people's needs.

Good

Our findings

We had very positive feedback from people about how caring staff were. One person said, "They know me very well. They are my friends more than my carers." Another person said, "They are excellent. Very caring." One person said what they really liked, was when they called the office, staff instantly knew them from the sound of their voice without having to say their name. The person went on to say that the care staff knew them so well that care staff knew when to be. "Soft and cuddly with me. I call it my times when I need 'hug and a drug'."

We observed warm caring relationships. Staff smiled and evoked smiles in people they supported. When staff were supporting a person with their morning routine we heard much chatter and occasional laughter coming from upstairs. We heard singing and joking. The person told us, "They [care staff] have a great sense of humour. They do not tell me what to do. I feel in charge." This feeling of self-determination and ability to determine how to spend ones day was mentioned by others. People told us that they had choice and could make decisions about their care. People had control of their lives and were listened to with staff respecting their views and acting upon them. Staff informed people of each task they were going to carry out and sought consent.

When staff spoke to us about people they knew them well and spoke warmly about the support they provided. One staff member explained that she understood and knew someone so well that they could interpret their behaviour that signalled the start of a urine infection. A live in carer told us how people were always personally introduced. Explaining, that the planned carer and the person spent time together, getting to know one another before they were responsible for the care. A person explained to us, "Their communication is so good. They are genuinely interested in me as a normal person." Another person said, "I feel well looked after and loved."

People's dignity and privacy was maintained by staff. Care plans for people stated how dignity was to be maintained and involvement in decisions in directing care. We observed that care staff were mindful of peoples dignity and privacy. One person told us, "I particularly like that the staff are mindful of others who live in the same house. They respect my [relatives] chair and bed. That's important to us." People were able to choose if they preferred a male or female member of care staff. This information was noted on the computer system and therefore the rostering system would 'block' the gender not required from visiting a person when determining the rosters. This ensured peoples choices were consistently known.

We observed that staff were mindful of peoples independence. Staff did not assume peoples abilities but

allowed people to try whilst guiding them and being there. We saw two separate examples of this. One person told us how staff brought them their medicines on a tray that had been set out by the person and not moved. This enabled them to remain in control of their medicines and know the order in which to take them.

Good

Our findings

People received personalised and responsive support. Feedback from people consistently showed that the provider was responsive to their needs. People spoke about the level of communication being thorough and consistent. A person explained that they knew if an event had happened to them then the whole of their care team would know. They believed this was down to the regular team meetings where they knew their changes were discussed. The other factor was a very successful computer system that was used to determine staffing rounds, for consistency, but also enable messages to be added to staff whilst on their care round. For instance if a person called the office and requested that staff whilst on route picked up an item for them from the shop or the chemist then this message could be added to the call round for staff to access on route. A relative told us, "We know all the staff that come. There is sufficient time to ensure that everything is done, including the mornings for a shower."

We observed that staff asked if there was anything else that could be done before they left once the known support needs were met. The daily notes completed by care staff were located in each persons home for them to read. They were clear and stated the support delivered on that occasion. Care staff told us that they always looked at what other staff had completed to ensure consistency of care. Care plans contained information on peoples requested routines and the support they required. People told us that they had been involved in the development of care plans. We could see that these were regularly reviewed. There were systems in place to have one designated staff member responsible for having oversight of records completion, updates and ensuring records were filed and replenished.

People with live-in carers were enabled to live full lives with flexible personalised support. They were able to go out on trips, for example specific clubs for rehabilitation, as they wished, as staff were always available to meet their personal care needs when they were out. One person told us that their care staff, "Sit with me whilst I watch TV or they read to me. They prepare all my meals too."

People were supported with all aspects of care and support planning. This included arrangements and support at the end of their lives. Staff were confident that they were supported to do the right thing in such circumstances. They were able to tell us confidently about their experiences and links that they had with local hospices and health professionals where they had ensured people had the end of life experience that they chose. People were supported to access services that ensured they had symptoms such as pain and nausea assessed and managed effectively. Within the care staff team there were people who had nurse training who also were enabled to use their skills in these cases where people wanted support at the end of their life. One staff member spoke of how they had learnt on the job from other more knowledgeable staff. "I

feel confident to work with palliative care. I know how to roll a person in pain, or to minimise movement. I know how important it is to be empathetic. But most of all it is about dignity." In our survey 100% of people said they were always treated with dignity and respect.

Peoples concerns and complaints were used to improve the quality of care. There were policies and procedures in place that people were aware of. People had knowledge of who to raise concerns with. Two separate people said, "I would be confident to complain if needs be and would contact Ann Mason." One person added, "I know nothing is too much trouble for them to resolve." There was a positive view about the receipt of concerns. Records were kept of matters with outcomes that drive improvements. For example one person had complained of a missed call. This had been followed up with a meeting to work out how this came about and as a staff team how this could be prevented from happening again. Additional actions such as the introduction of a white board were in place and roster to prevent again for that person. The individual was sent the outcome along with an apology.

Good

Our findings

At the previous inspection dated 31 October and 2 November we had rated this section as requires improvement. We said changes were positive, but there had not been enough time for them to become fully embedded and for us to measure whether improvements were fully sustainable. We found at this inspection that changes had been sustained and were working well. We had thought some changes were ambitious, for example the manager told us they were planning to have team meetings fortnightly. However, we found that regular meetings had been sustained and ensured clear communication between all staff supporting people. Due to the frequency of meetings it meant that staff were rostered and paid to attend meetings and staffing support to people was maintained. This showed that the manager knew her service well and knew what would work well for them.

The manager continued to show strong leadership and ensured the checks and supervisions of the live-in carers were consistently in place and had devolved this responsibility to another team member now that it had been established. There was oversight of the quality and thoroughness of the checks on all new staff, including the live-in carers. We found evidence form a variety of sources that told us weekly checks were completed on live in care staff. The manager had clear systems to monitor incidents, accidents and complaints. All of which were used to positively develop the service.

Staff were listened to and views actively sought through regular one to one sessions and frequent team meetings. The manager had a grasp of staff training and knew from the training matrix when training was required to be updated. Staff were given opportunities such as completing the dementia training known as 'virtual dementia tour' and enabled to progress and achieve professional qualifications. People who used the service were involved. An annual survey was completed to seek people's views. The last survey was completed in March 2017. It was positive about staff and their ability to offer choice and dignity. The survey was due to be repeated, but was being revised to make it more progressive.

People we spoke with about how the service was managed and delivered were very positive. One person said, "I would recommend this service to people and have done so." A member of staff said, "I see progress they make all the time. They really listen to the staff and support them." A different staff member said, "I would describe Ann Mason as lovely, approachable. Always available to me and others. Her management style is fair, trying to accommodate and balance everyone's needs." One staff member said, "I love my job, the responsibility it brings, the people. The boss accommodates people and we could not ask for better." We found an organisation that was open and transparent with caring visible management leading and developing the service.

Since that last inspection the data base and computer based systems developed had been a great success and well worth the investment for the service. The systems developed enabled the smooth running and oversight of the daily business. The system enabled visits to be scheduled effectively to suit people and staff, but alert the office if there were any concerns.

The manager and other staff demonstrated an enthusiasm to introduce best practice, and engaged positively with outside organisations to ensure they had access to good quality information and resources. For instance, the manager had completed a long course with. 'My Home Life Essex'. This is a leadership support programme. It contained materials such as, understanding the new CQC changes to inspection and key lines of enquiry. This was evident in how well and comprehensively the manager had completed the PIR information returned to us at CQC. The PIR told us that as an agency they had been involved with a local Parkinson's awareness group. This was to pilot schemes to access patients isolated in rural areas. Another are of developing practice was that the manager had been involved with a parliamentary review on care that was published in 2018. We saw there were strong links with the two neighbouring local authorities and a desire to develop and ensure sustainability within the agency. The service was very well led and was keen to improve and develop new ways of delivering care and support to people to enable to remain living independently.