

Care Outlook Ltd

Care Outlook (London Office)

Inspection report

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26 January 2017

19 February 2017

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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

This inspection took place on 19, 24 and 26 January 2017 and was announced. This was the first inspection of regulated activity carried on by the provider at this location.

Care Outlook (London Office) is a domiciliary care agency providing personal care and support to people in their own homes. At the time of the inspection the service was providing support to 501 people. The provider met a range of needs including those of older people, people with physical disabilities and people with a learning disability.

The service had a registered manager at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider helped to keep people safe by assessing and managing their risks. Staff received training in safeguarding and understood how to identify abuse and the actions they should take if they suspected it. Staff were recruited through a robust process and there were enough staff to deliver care and support to people. Staff supported people to receive their medicines in line with the prescriber's instructions. People were protected by the infection prevention and control practices of staff.

People received care and support delivered by trained and supervised staff. Managers and staff understood their responsibilities in relation to the Mental Capacity Act 2005. People received the support they required to eat and drink enough and staff ensured that people had ready access to healthcare professionals when required.

Staff were caring and kind towards people. People were treated with dignity and respect. Staff promoted people's independence and people were encouraged to make decisions. People approaching the end of their lives were supported with end of life care plans.

People received personalised care that met their individual needs. People's needs were assessed and they were involved in the care plans designed to meet their needs. The level of support people required was reviewed regularly. The service responded to complaints in a timely and appropriate manner.

The service had a registered manager. Staff felt supported by their line managers. Quality audits and checks were undertaken to review and improve the quality of the service. The provider worked in partnership with other agencies.

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. Staff received safeguarding training and knew how to protect people from abuse.

People's risks were assessed and plans put in place to mitigate them.

There were enough staff available to safely deliver care and support as planned.

People received their medicines safely.

People were protected against avoidable infection.

Is the service effective?

Good ●

The service was effective. People received support delivered by trained staff.

Staff were supervised and appraised by managers.

People were treated in accordance with the principles of the Mental Capacity Act 2005.

Staff provided people with the support they needed to eat and drink.

Staff and managers ensured people had timely access to healthcare services.

Is the service caring?

Good ●

The service was caring. People told us the staff were caring.

People shared positive relationships with staff.

People were encouraged to be independent.

People were treated respectfully.

Is the service responsive?

Good ●

The service was responsive. People's needs were assessed and reviewed to ensure the service was meeting them.

Care plans were personalised and met people's needs.

People's complaints were responded to appropriately.

Is the service well-led?

Good ●

The service was well-led. There was a registered manager in post.

The service had effective quality assurance processes.

The service worked with other agencies to meet people's needs.

The registered manager received support from the provider organisation to promote good governance.

Care Outlook (London Office)

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 announced inspection took place on 19, 24 and 26 January 2017. The provider was given 48 hours' advance notice because the location provides a domiciliary care service and we needed to ensure the registered manager and staff were available. The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about Care Outlook (London Office) including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We used this information in the planning of the inspection.

During the inspection we spoke with 20 people, 20 staff, one care coordinator the registered manager and the provider's director of operations. We reviewed 37 people's care records, risk assessments and medicines administration records. We looked at documents relating to staff and management. We reviewed 14 staff files which included pre-employment checks, training records and supervision notes. We read the provider's quality assurance information and audits. We looked at complaints and compliments from people and their relatives.

Following the inspection we contacted 22 health and social care professionals to gather their views about the service people were receiving.

Is the service safe?

Our findings

People told us they felt safe. One person told us, "I feel very safe with them [staff who deliver care and support]."¹ Another person said they felt, "Very safe". Whilst a third person told us, "They're very good. I don't feel worried."

People's safety was enhanced because staff received training in safeguarding and understood the provider's safeguarding procedures. Staff knew to report to their manager any concerns that a person might be at risk of abuse. Staff also understood the provider's whistleblowing policy. One member of staff told us, "We have an important role as we are the ones who have to speak out and keep people safe."

People's risks of preventable harm were reduced because staff and managers assessed people's risks and plans were put in place to manage them. For example, one person who was at risk of choking received an assessment from a healthcare professional and was supported to have a soft pureed diet. Another person who presented with the same risk had a care record which stated, "Be patient with [person's name] and check that they have no food in their mouth before giving them more as they could be at risk of choking."

Care records provided staff with people's living arrangements and access details. For example, one person lived alone and staff entered their home to deliver care using a key safe. Whilst another person answered the door to staff when they arrived. There were procedures in place in the event of people not answering the door when staff arrived. This included knocking on people's windows, calling through the letterbox, speaking to neighbours and contacting office based staff who phoned relatives. Managers assessed the risk associated with no responses and had alerted social services and on occasion the police who then forced entry to establish people's safety and well-being.

The provider operated a weather alert system to keep people safe. The system was used for severe weather conditions including, heavy snow fall, heatwaves and floods to ensure that care visits were prioritised based upon people's risks. For example, one person who was ordinarily at low risk and was able to shop independently was assessed to be at high risk of malnutrition if poor weather prevented them from leaving their home to buy food. Other people identified to be at high risk were people who required time critical medicines and people with high mobility needs. This meant that risks to people were reduced because of the service's risk management and contingency planning.

There were enough staff to ensure people received their care as planned. Staff told us they were happy with their rotas and had sufficient travel time between care visits. This reduced the risk of staff being late to deliver support. The provider's policy was that staff and people should not share telephone numbers. If staff were running late they contacted the office who in turn informed people. This meant that managers knew when people were not receiving care as planned. We found that when care visits had been missed the service investigated the incidents to determine the cause of the event and its impact on people and took steps to prevent recurrence. In some instances disciplinary action was taken.

People were supported by vetted and suitable staff. The recruitment process included the submission of an

application and attendance at an interview. The provider satisfied themselves as to the identities of prospective staff by checking documents including passports and driving licenses. Applicant's details were checked against criminal records lists and individuals barred from working with vulnerable adults.

Staff supported people to receive their medicines safely. Peoples' capacity to take medicines was assessed and the support they required to take their medicines safely was stated in care records. For example, some people required staff to prompt them to take their medicines whilst other people required staff to hand medicines to them. Staff signed people's Medicines Administration Record (MAR) sheets to confirm people had taken their medicines in line with the prescriber's instructions. Managers audited MAR charts and assessed staff competency to administer medicines through observation during spot check visits at people's homes.

The arrangements about how people collected their medicines was also stated in care records so they did not run out of medicines. For example, some people collected their medicines from the pharmacy. Pharmacy services delivered medicines to some people's homes. Whilst some people's medicines were collected by staff on their behalf. Care records also stated the location within people's homes where medicines were kept.

People told us they felt safe when staff used equipment to support them. One person told us, "They know my equipment and I feel safe with them." Another person said, "I have an electric wheelchair and [staff] put it on charge each night." Care records contained details about the locations of people's main water shut-off valves and electrical fuse boxes. Gas emergency telephone numbers were also noted. This meant staff had information to keep people safe in an emergency.

People were protected from infection. Staff used personal protective equipment (PPE) when delivering personal care. For example, staff wore single use gloves and aprons when carrying out activities with a higher risk of cross infection. Where people were at risk of infection staff had guidance about how to minimise the risk.. Care records provided guidance to staff when people had pets. For example, one person's care records stated, "Make sure the dog does not go near [person's] food when they are eating as this is a contamination risk."

Is the service effective?

Our findings

People were supported by knowledgeable staff. People spoke positively about the competence of the staff they received support from. One person told us, "They're good my carers, they know exactly what they are doing." Another person said, "Their skills are fine."

People received care from trained staff. The service ensured that all staff received training in core areas. These included, medicines, moving and handling and keeping people safe. The service also delivered additional training to staff that was specific to people's needs. This included specialist feeding techniques, end of life care, dementia awareness and the administration of medicines to prevent blood clots. A member of staff told us, "This training gave me confidence on the process for administering [anti-clotting medicine]." This meant staff received the training required to meet people's needs effectively.

New staff received a comprehensive induction. Upon joining the service staff attended a four day classroom based induction course. This covered areas including, principles of care, infection control, moving and handling, and food hygiene. Staff were then supported to complete the care certificate within 12 weeks. During this period staff shadowed experienced colleagues as they delivered care and support. This enabled them to meet people, become familiar with their needs and observe good practice in delivering care. This meant people were supported by new staff who were familiar with their needs and preferences.

People received care and support from staff who were supervised by their line managers. Office based supervisors phoned people to obtain their views as to how staff delivered their care. In addition, managers visited people's homes and observed staff providing support. Care staff and their supervisors were supported with one to one meetings with managers when people's changing needs were discussed.

Managers evaluated the performance of staff. Most staff received annual appraisals from their line managers and plans were in place to appraise the remaining staff. These meetings were used to review how staff had delivered care to people and to plan staff development. Professional development included identifying the skills staff wanted to acquire and the training courses they would benefit from attending.

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.

Staff and managers understood their roles in relation to the MCA. People, staff and records confirmed that consent was given to care and support. Where people lacked capacity best interests meetings took place to plan their support. When people declined support this was reflected in records and social care professionals were informed.

People received the support they were assessed as requiring to eat and drink. Care records stated people's

preferences for meals. For example, one person's records stated, "During lunch I would like my carer to prepare fruit for me." Another person's stated, "At lunch I like to have a sandwich of my choice with tomatoes on the side." Where people had a poor appetite, care records gave staff advice. For example, one person's care records explained, "Coaxing and patience will be required." Another person's care record said, "I may say I don't want anything to eat but I would still like my carer to prepare me something to eat, I may eat it after [they] have left."

Staff supported people to access healthcare services in a timely manner. Records showed people were referred to healthcare professionals when their health needs required. Staff supported people to attend appointments and to receive visits from healthcare professionals. Staff maintained records of people's health and the outcomes from their health appointments.

Is the service caring?

Our findings

People told us that care staff were caring. One person told us that staff were, "Very kind and caring". Whilst another person said, "They're very compassionate. They are very helpful." A third person told us, "They're friendly and nice." A fourth person said care staff were, "Always nice and polite to me."

People were supported to develop positive relationships with staff. People told us that regular staff had supported them over a period spanning years which meant staff knew their needs. One person said, "The service they provide is good they put me at ease." A member of staff told us, "We get to know people well which helps when we deliver care. They trust us." Another member of staff told us, "We have regular service users on our list so we all get to know them. People like that. That makes for good care."

People were supported to make decisions about the care and support they received. Care records stated people's preferences regarding their personal care. For example, one person's care records stated, "I would like my care worker to assist me with having a strip-wash each morning and help me choose appropriately coordinated clothes to wear." People were asked to choose how they were supported at each care visit. A member of staff told us, "[I] find out what people want and listen to their views. For example, whether they would like a bath or wash today." Another member of staff said, "We give choices where we can for example the clothes they would like to wear,"

People's independence was promoted. Care records illustrated the areas where people did not require support. For example, one person's care records stated, "I am able to do my housework independently and do not require any assistance." Another person's stated, "I have my own teeth and do not need assistance to brush them." Where people required support to be independent this was stated. For example, one person's care records instructed staff to, "Encourage and promote independence by giving the flannel to [person's name] to wash the areas of the body they are able to reach." In another care record a person said, "Leave required possessions within reach, e.g. TV remote, drinks and fruit".

People's dignity and privacy were respected. One person told us, "Anything they want to do they ask my permission even when they clean the house." Care records were written in a way that showed respect for people's dignity. For example, one person's records stated, "Unfortunately I am unable to get in and out of bed as I used to. I would like my care worker to assist me to get dressed into my night clothes. I would also like to use the commode before I go to bed." Another person's care records instructed staff to, "Ensure [person] is comfortable and safe before leaving." The names by which people preferred to be addressed were noted and used throughout care records.

People who had end of life care needs had care plans in place to address these. Staff providing care and support to people receiving end of life care worked collaboratively with a local hospice and Macmillan nurses to help ensure that people had dignified and pain free deaths.

Is the service responsive?

Our findings

People were supported with personalised care that was responsive to their individual assessed needs. One person told us, "I take it as granted anything I want done they do." The service completed a matching process to link the care needs of people to the training and experience of the care staff. This meant people were supported by staff capable of meeting their needs.

People's needs were assessed by health and social care professionals and by the service's managers before care and support were delivered. This meant the service knew if it could effectively meet people's needs. The service was flexible in its delivery of support to meet people's preferred times for care delivery. We read that people were supported to change the timing and duration of their care visits. For example, one person was supported to reduce one care visit by 15 minutes and increase another by the same amount of time each day.

People's changing needs were identified, reassessed and met. People were supported with reviews when their needs changed. For example, when one person's mobility needs increased significantly they were supported with a reassessment. This resulted in two staff being required to deliver care with the use of a hoist. Staff had guidance in care records to notify managers should they observed any changes in people's needs. For example, one person's care records stated, "If [named person's] mobility deteriorates, inform the office to discuss a further moving and handling risk assessment."

People's care plans provided staff with clear guidance on how to provide people's care and support. One member of staff told us, "We have access to the care plans and read them before supporting a new person." A second member of staff said, "We get very clear instructions before visiting any client." Care plans stated the support people required for their assessed needs to be met. Where there were challenges in the delivery of personal care staff had guidance. For example, one person's records stated, "Both care workers to complete personal care on the same side of the bed as there is not enough space to allow the bed to be moved and for each care worker to be on either side."

Where family members supported people to have their needs met this was stated clearly in care records. For example, care records noted that a person's relatives did their weekly shopping and gave them their medicines. "My [relative] manages my finances." "My relative will prepare my meals". "This meant people, relatives and staff knew where the responsibility for meeting specific care tasks lay.

People were supported to overcome social isolation. One person's care package included a sitting service, where staff provided company to them. We read one care plan in which a person had stated, "I would like my carer to stay with me for a few hours on Mondays and Fridays for company." We found that the service supported another person by making a referral to a befriending service.

People and their relatives knew how to make complaints. The service investigated complaints and provided written responses to complaints within the timeframe stipulated in the provider's policy. When complaints were received via the local authority the service undertook investigations of the specific concern and

reported back to social care professionals. At the time of the inspection a survey was being sent out to people to obtain their feedback about the quality of care they were receiving.

Is the service well-led?

Our findings

The service had a registered manager who was supported by a team of care coordinators, quality monitoring officers, contract managers and supervisors. Staff described the culture of the organisation as open and friendly and a good place to work. One member of staff said, "Managers are very friendly and responsive they sort things out for you." Another member of staff said, "Very good management, they listen to you." A third member of staff told us, "If you do have any worries the manager listens and sorts it out." We observed staff coming into the office to have unscheduled meetings and informal conversations with managers during our visit to the office.

We received mixed views about the service's communication internally with staff and externally with people. However, we found that people and staff had acknowledged improvements by the office. One member of staff told us, "Communication with the office team had been problematic but after this had been raised with the manager communication had been improved." These improvements included employing a permanent on call care coordinator and having the provider's office open and staffed seven days a week. This meant people and staff had access to management support and guidance at all times.

Managers ensured that care records were accurate and up-to-date. Staff completed daily notes in peoples' care records. Where two staff were required to deliver care and support at the same time both signed the entries made into care records. The quality of record keeping was reviewed by manager's when they visited people's homes. Notes from these visits recorded managers answering the question, "Is the [care staff's] handwriting neat and legible." Daily records notes detailed the support people received as well as people's physical and emotional wellbeing at the time. These were regularly returned to the office for auditing and archiving. Where issues were identified managers took action. Care plans contained fact sheets to inform staff. These included information on health conditions including epilepsy and dementia.

The quality of care people received was monitored and reviewed. Managers undertook a range of quality assurance activities. These included direct observation of staff supporting people with personal care, breakfast preparation and administration of medicines. Observations were undertaken during unannounced spot checks. The views of people were gathered by managers during spot checks by asking questions such as, "Do staff arrive at the expected time?" This meant managers assessed whether care was delivered as planned and to people's satisfaction.

The provider worked in partnership with social care professionals including social workers and commissioners to plan people's care. The service also collaborated with healthcare professionals to meet people's needs. This included, working alongside district nurses supporting people's skin integrity and speech and language therapists to support people to eat and drink safely.

The registered manager received support from the provider. This included supervision from the director of operations and the opportunity to regularly meet with registered managers from the provider's other offices to discuss the delivering of care. The registered manager attended meetings of the local authority's providers' forum where best practice was discussed and the information used to improve the service.

