Community Care Direct Limited

Community Care Direct

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

This inspection took place on 27 and 28 June 2018 and was announced

At the time of our inspection the service was providing packages of care to 18 people.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community [and specialist housing]. It provides a service to older adults and younger disabled adults. Not everyone being supported by Community Care Direct received personal care. The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks relating to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager in post.

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.'

During our last inspection in June 2017, we found no breaches of any of the health and social care regulations however the service was rated as requires improvement. This was because the service had previously been rated as inadequate and placed in special measures and we wanted to ensure the service could sustain good practice.

Staff were recruited safely and checks were made on their character and suitability to work. Staff were only allowed to work once these checks came back as satisfactory.

Risks assessments were in place and were reviewed regularly. Risk assessments were suitably detailed and contained information with regards to the management ofrisk.

Medication was stored in people's own home and administered safely. Where staff were responsible for administering people's medication this was done by trained staff who had had their competency assessed.

Staff were provided with Personal Protective Equipment (PPE) such as gloves and aprons in accordance with the service's infection control procedure.

Staff were aware of safeguarding procedures and were able to describe the action they would take to ensure people were kept safe from harm. This included raising alerts to the registered manager, local authority safeguarding teams, the police, or whistleblowing.

Rotas showed that staff were assigned their care calls using an electric monitoring system (ECM). Staff were issued smart phones and were required to 'log' in and out of calls to ensure people were getting their allocated time. Records showed this system had been implemented since our last inspection.

The registered manager and the staff understood the principles of the Mental Capacity Act 2005 and associated legislation.

People were supported with eating and drinking and staff were aware of people's dietary preferences.

Staff supported people to contact other healthcare professionals such as GP's and District Nurses if they felt unwell.

Staff undertook training in accordance with the registered providers training policy. Staff told us they enjoyed the training. Training was a mixture of e-learning and practical training sessions. Staff spoken with confirmed they had regular supervision and appraisal.

Additional role specific training took place to help people manage their support needs. This training was overseen by a registered nurse who assessed staff competency once they had attended the training.

People we spoke with were complimentary about the caring nature of the staff and we received positive comments about the registered provider in general.

People told us that they were always kept informed and involved in their care.

We did not observe care being delivered, however, people told us staff were kind and caring in their approach.

Care plans contained detailed information about people, what their preferences were and how they liked their care to be conducted. Information in care plans was regularly reviewed and updated in line with people's changing needs. This meant that the registered provider was responsive to people's needs and preferences.

Complaints were investigated in line with the complaints procedure and responded to appropriately.

Audits took place which checked service provision and action plans were implemented to improve practice.

Feedback was gathered from people using the service and people told us they felt that the registered manager had responded to their comments.

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 received their medications on time.

Staff recruitment was robust and checks were undertaken on staff before they started working for the service.

Risks to people were assessed, and there was information on how to manage these risks.

People told us they felt safe receiving care from Community Care Direct.

Is the service effective?

Good

The service was effective.

The staff had the correct training to support people effectively.

Staff received regular supervision and annual appraisals.

People were supported to eat and drink appropriately.

The service was working in accordance with the principles of the Mental Capacity Act and associated legislation.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring and treated them with dignity and respect.

People's preferences were reflected throughout care plans. This helped staff to get to know people and provide care based on their needs and preferences.

Care plans promoted people's choice and independence.

Is the service responsive?

Good

The service was responsive.

There was a process in place for recording, acknowledging and responding to complaints. People we spoke with told us they knew how to complain.

People received care which was planned and personalised in accordance to their preferences. Staff demonstrated that they knew people well.

Staff were trained to support people who were on an end of life pathway to remain comfortable in their home with additional support from other medical professionals.

Is the service well-led?

Good

The service was well-led.

The registered manager was aware of their role and had reported all incidents to the CQC as required.

People and staff told us they liked the registered manager. This indicated that the registered manager was visible and approachable.

There was regular auditing taking place of care files, medication and other documentation relating to the running of the service.

Community Care Direct

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 checked 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 27 and 28 June 2018 and was announced. The provider was given 48 hours' notice as the service provides domiciliary care, and we wanted to be sure staff and people who used the service would be available to speak with us.

The inspection was conducted by two adult social care inspectors.

We visited the office location on 27 June 2018, to see the registered manager, office staff and to review care records, policies and procedures. We also made phone calls to people in their own homes on 27 June and 28 June 2018. Additionally, we had requested some information to be sent to use by email before and after our site visit.

Before our inspection visit, we reviewed the information we held about Community Care Direct. This included looking at the notifications we had received from the provider about any incidents that may have impacted on the health, safety and welfare of people who used the service. We also looked at the Provider Information Return (PIR) we received from the provider prior to our inspection. This form asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We spoke to five people who used the service. We spoke with five staff, the registered manager and provider. We looked at the care plans belonging to four people and other related records. We checked the recruitment files for four staff. We also looked at other documentation associated with the running of the service.

Good

Is the service safe?

Our findings

We received positive feedback about the safe level of care people received. Comments included, "I feel really safe", "I have no issues or concerns with the service" and "The staff are good at coming on time."

We looked at how staff rotas were managed by the service. We saw that people's call times were adequately spaced, with enough travel time in between calls for staff to get to and from people's homes on time. Staff we spoke with told us that they were happy with their rotas and they mostly visited the same people. This meant that staff were able to develop relationships with people, and the registered provider offered consistency for people receiving care.

We discussed the procedure for Electronic Call Monitoring (ECM) with the registered manager. ECM is a technology where carers 'sign in' to their calls either using a smartphone or the person's home telephone. This then alerted the office staff or out of hours on call that a carer had attended the call. The registered manager used the data collected from the ECM system to check when staff were late, or had not logged in at all to help people. The length of calls were monitored to ensure that staff stayed for the required duration of the call. The electronic records that we viewed confirmed that almost all calls had been delivered as commissioned. We also saw evidence that people had been telephoned by the office staff in advance to inform them if staff were going to be late.

Staff where able to explain the course of action that they would take if they felt someone was being harmed or abused. Staff we spoke with said they would 'whistle blow' to external organisations such as CQC if they felt they needed to. Staff had received training in safeguarding and their responses were in line with procedures set out in the service's safeguarding policies. This stated that staff should report all protentional abuse to the appropriate authorities. Information regarding safeguarding for people who used the service and relatives was readily available on the noticeboards in the office and the service user guide. People we spoke with confirmed they knew how to raise concerns should they have any.

Accidents and incidents were accurately recorded and were reviewed by the registered manager in order to identify any patterns and triggers. This meant that the registered manager was overseeing if trends were being established and how to safely manage risks. Care records were detailed and included reference to any follow up actions that were needed following any accidents and incidents.

Staff completed risk assessments to assess and monitor people's health and safety. There were risk assessments and management plans in place for falls, manual handling, pressure care and nutrition. Each care plan contained risk assessments which showed the relevant risks, control measures and how to mitigate the associated risks. For example
risk assessments were highly detailed and contained a lot of information regarding people's care needs. We saw that one person had a grade four pressure sore which needed to be robustly managed. There was information about the routine of the district nurses, this had then been incorporated into the registered providers own 'turn charts' so that pressure relief care could be clearly recorded. There was also a risk assessment around the pressure relieving mattress and catheter support. There was detailed information

about the risks of having a catheter such as infection, how to identify the risks, and manage those risks. This meant that staff had clear information about management of risk and how to safely mitigate risk.

Each care file contained an environmental risk assessment. This had been completed at each person's home during the initial assessment process to highlight any potential hazardous working conditions for staff such as pets or stairs. Action had been taken to minimise risk to both staff and the person they supported.

We reviewed four personnel files of staff who worked at the service and saw there were safe recruitment processes in place including; photo identification, employment history, two references and Disclosure and Barring Service (DBS) checks. DBS checks are carried out to ensure that staff are suitable to work with vulnerable adults in health and social care environments.

Staff were supplied with personal protective equipment (PPE). This included gloves, aprons and hand sanitizer. Staff we spoke with told us they were always able to ask for more PPE when needed. Staff had completed infection control and prevention training, and understood the importance of reporting outbreaks of flu and vomiting to the registered manager, so they could cover their work so as not to spread the infection.

Good

Is the service effective?

Our findings

People we spoke with told us they were supported by staff who had good training and skills. One person said, "I find them very knowledgeable" and someone else said "The certainly know what they are doing."

We viewed the training matrix. Training was a mixture of e-learning and practical sessions. For example, staff received practical training manual handling and medication. When additional training was needed this was sourced separately. We saw additional training was in place to help support people with their bowel care needs. This was because some people had a spinal injury, and wanted to remain as independent as possible for most aspects of their care. We spoke with one care worker who had completed this training and were able to explain the process to us. We saw that each of the trained carers had undergone specific competencies which were then 'signed off' by a dedicated professional. This showed that the registered provider respected people's diverse needs, choices and preferences in relation to how they wanted their care to be delivered.

Staff were required to complete competency assessments to ensure they were able to administer medication. We checked certificates for training courses staff had attended against the training matrix we were provided with and found that the dates matched for the courses attended. This meant that staff training was up to date. New staff were inducted in accordance with the principles of the Care Certificate. The Care Certificate requires staff to complete a programme of learning and have their competency assessed before working independently. Staff attended formal supervisions every three months and received an annual appraisal.

We saw that new staff were subject to 'shadowing' (being paired with more experienced members of staff) and more regular supervisions. The registered manager informed us that this was because they wanted to ensure new staff felt supported. Staff we spoke with confirmed they received plenty of supervisions and support.

We saw that people had been pre-assessed before their care package commenced. This involved the registered manager meeting people in their homes prior to the care package being put into place to look at what support they needed. People's care plans were completed in accordance with their diverse needs and preferences. For example, one person's care plan stated they wanted to continue to self-medicate, despite needing high level support with other aspects of personal care. This was recorded in their initial assessment and then further developed in their care plan.

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 to see whether the service was working within the principles of the MCA. We found that care and support was provided in line with people's best interests which was assessed at the beginning of the care package. This was then reviewed at a later date if there had been any changes to people's capacity and or the person's inability to consent to the care and support provided. Care plans were signed by the person themselves or a family member who was legally able to do so.

People we spoke with said staff would offer to call the GP on their behalf if they felt unwell. Each person had contact details for their GP and pharmacy in the front of their care plan. This meant that staff were supporting people with their medical needs and appointments.

People told us they were supported with their meals by staff, and raised no concerns over this. Staff we spoke with told us they completed paperwork in some people's homes to document what they had to eat or drink daily. This was to ensure people retained a good diet and fluid intake.

Good

Is the service caring?

Our findings

Everyone we spoke with told us that they liked the staff and they were caring. Comments included, "Such a good little team", "They [staff] really treat us and the house with respect and"We get on very well."

We asked people about the need to respect privacy and dignity. People told us that staff respected their right to privacy and were mindful of this when providing personal care.

We asked the staff how they provided dignified and diverse care to people. One staff member told us they always knock on doors and say who it is before entering the person's home. Staff we spoke with spent time talking fondly about the people they supported and said they enjoyed their jobs.
Staff told us that they enjoyed providing support to people and were able to explain how they involved people in making decisions about their day-to-day care and support. It was clear from discussions that staff knew the people they supported well. When we spoke with staff they described the person and their needs in detailed, positive terms.

Care plans evidenced that people had been involved in discussions and changes to their care needs. Care plans were signed by people themselves, their family members (where legally allowed to do so) or via a best interest process where other family members or friends had been consulted in the person's decision making. One person told us, "I am involved in my care plan."

Each care record contained a section which addressed capacity, choice and control. People or their relatives had signed the documents to say that they agreed with the contents. People were clear that they had choices regarding how and when support was given. For example, one care record outlined how the person required specific support to transfer and what help was needed from staff in order to do this.

For people who had no family or friends to represent them contact details for a local advocacy service were made known to them via signposting from Community Care Direct. There was no one accessing these services at the time of our inspection.

During the inspection we checked if confidential and sensitive information was protected in line with Data Protection. All information was safely secured at the registered address and was not unnecessarily shared with others. The 'registered address' is the address which has been registered with CQC and is the address where all records and documentations should be safely stored.

Good

Is the service responsive?

Our findings

Our assessment of care plans and conversations with people using the service evidenced that people were receiving care which was right for them, based on their needs and wishes. The service was operating in a person-centred way. This means that care was coordinated around the needs of the individual person, and not the service.

There were good person-centred care profiles in each file. Each one contained details such as the name each person preferred to be called and people who were important to them. There was plenty of personal detail for example 'I like to have breakfast, I like eating and have a healthy appetite'. There was a heading called 'tips to talk to me about' which acted as a good ice breaker between staff and the person using the service. There was a section about the person's background including information about their skills and interests for example 'I used to crochet, now I like to watch television and go shopping'. There was also information about the person's religious beliefs. Additionally, there was a person-centred care plan with details such as next of kin, allergies, contact details for external health professionals and social workers.

There were detailed routines for each person. They were very person centred and it was evident that each person had had a lot of input into their care plan. For example one morning routine detailed how to get the person up and showered and even which coloured flannel they had for the different parts of their body as well as their preference of a small bowl of granola and a cup of tea for breakfast. Another person's routine stated that they liked three apricots and prunes. This shows that the registered provider was taking the time to get to know each person they supported, and ensured their needs, choices and preferences were clearly documented.
Care plans contained a detailed medical history and there was a support plan which provided carers with sufficient detail about the preferences of each person. For example, how they are day to day their preferred diet and choice of food, what may make them upset and how best to support them when became distressed. For example, at night-time one person liked their television and lamp left on with the door slightly open.
'Equality and diversity support needs were assessed from the outset. Protected characteristics (characteristics which are protected from discrimination) were considered at the assessment stage and included age, religion, gender and medical conditions/disabilities. This meant that the registered provider was assessing all areas of care which needed to be supported and established how such areas of care needed to be appropriately managed'

Staff were trained in end of life care. People were supported to remain at home if they wished, supported by staff and other medical professionals. People had information in their care plans regarding what arrangements would be needed in the event of their death. The service had recorded and responded to people's deaths appropriately and sensitively.

People and their relatives told us they were aware how to make a complaint and they would have no problem in raising any issues. The complaints and comments that had been made had been recorded and addressed in line with the complaints policy. We checked some recent logged complaints and saw they had

been responded to in line with the provider's procedures. The policy contained details of the Local Authorities safeguarding procedures as well as the contact details for the Local Government Ombudsman (LGO) if people wished to escalate their complaint.

Good

Is the service well-led?

Our findings

People we spoke with referred to the registered manager by name and said they had often spoke with them. One person said, "It is good because [registered manager] will always call you back if needed." Staff we spoke with said that the registered manager was helpful and supportive.
There was a registered manager at the service who had been in post since our first rated inspection.

The registered manager was able to demonstrate that they had gradually improved their approach to providing a safe service. This was evident in the registered providers and registered managers action plans which they had been sharing with us. We spoke to people who said they had noticed a huge improvement in the service and this made them feel reassured. Additionally, everyone we spoke with said they would recommend Community Care Direct. This demonstrated that the service had acted on requirements to improve and had managed to sustain this improvement in the last twelve months.

Team meetings took place every few weeks and we saw some of the minutes for these. Agenda items included safeguarding, training, and recruitment.

The service had policies and guidance for staff regarding safeguarding, whistle blowing, involvement, compassion, dignity, equality and safety. There was also a grievance and disciplinary procedure and sickness policy. Staff were aware of these policies and their roles within them. This ensured there were clear processes for staff to account for their decisions, actions, behaviours and performance.

The registered manager discussed lessons they had learnt from their past inspection which included more documented evidence of the inspection processes and the development of their own action plans.

People were regularly contacted by the service to ask for feedback with regards to their care package. We saw that the service had been doing three monthly telephone reviews, however this had not been completed since January 2018. The registered manager informed us this was something they felt was effective but they would be put back into place in order to strengthen QA systems and act on feedback provided.

We looked at the quality assurance systems and processes to monitor how the service was operating and to drive forward improvements. A range of audits and checks were undertaken. The registered manger completed a management audit each month. The checks included care files, staff training and medication. Medication audits in people's homes were completed each month. We checked these audits over the last few months and saw that any errors that had been highlighted had been promptly followed by robust action plans for the care staff to follow.

Completed medication administration records (MAR) were checked by the registered manager when they were returned to the office. We saw monthly audit paperwork which included missed calls report, Incident report and the CQC report. We also saw a daily audit which took place which involved the running of

'reports' from the ECM system which focused on staff logging in time and peoples visit times. If staff were not staying for the duration of their call this was then investigated by the registered manager. The registered manager informed us that the current ECM developers were in the process of developing the system so all audits could be populated and stored within the system so they were accessible in the one place.

The service worked well with the local authority and Continuing HealthCare (CHC). We saw that relationships had been developed, and this was demonstrated in the services ability to ask for support to train their staff with regards to specific tasks.

The service was involved in local sponsorships and had good oversight with regards to ensuring staff were offered competitive employment packages in order to apply and stay working with Community Care Direct.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Community Care Direct was displayed in the main part of the building, and the registered provider's webpage.