Caronne Care Limited

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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

This inspection took place on the 7 December 2017 and was announced. At the previous inspection of this service in July 2016 we found three breaches of regulations. Staff were not always punctual, the service had not always notified the Care Quality Commission (CQC) of allegations of abuse and quality assurance systems were not being properly implemented. We found these issues had been addressed during this inspection.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe and well-led to at least good. The action plan set out the action they planned to take and during the inspection we found it had been taken and issues had been addressed.

This service is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older adults and younger disabled adults. 117 people were using the service at the time of our inspection.

The service had a registered manager in place. 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.

Appropriate safeguarding procedures were in place and people told us they felt safe using the service. Risk assessments provided information about how to support people in a safe manner. There were enough staff working at the service to meet people's needs and robust staff recruitment procedures were in place. Medicines were managed safely. Staff had a good understanding about infection control issues and used protective clothing to help prevent the spread of infection. Lessons were learnt when accidents or incidents occurred to help improve the service.

People's needs were assessed before they began using the service. Staff received training and supervision to support them, in their role. Where the service supported people with meal preparation they were able to choose what they ate and drank. People were supported to access relevant health care professionals and the service worked with other agencies to support people. People were able to make choices for themselves where they had the capacity to do so and the service operated in line the Mental Capacity Act 2005.

People told us they were treated with respect and that staff were caring. Staff had a good understanding of how to promote people's privacy, independence and dignity.

Care plans were in place which set out how to meet people's individual needs and these were subject to review. The service had a complaints procedure in place and people knew how to make a complaint.

Staff and people spoke positively about the registered manager. The service had various quality assurance and monitoring systems in place, which included seeking the views of people on the running of the service.

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. Appropriate safeguarding procedures were in place and staff understood their responsibility for reporting any safeguarding allegations.

Risk assessments were in place which provided information about how to support people in a safe manner.

The service had enough staff to support people in a safe manner and robust staff recruitment procedures were in place.

Medicines were managed in a safe manner.

Systems were in place to reduce the risk of the spread of infection.

Where accidents and incidents occurred these were reviewed so lessons could be learnt to help prevent further such incidents.

Is the service effective?

Good

The service was effective. People's needs were assessed prior to the provision of care to determine if the service was able to meet the person's needs.

Staff undertook regular training to support them in their role. Staff had regular one to one supervision meetings.

People were able to choose what they ate and drank.

People were supported to access relevant health care professionals as required and the service worked with other agencies to promote people's health and wellbeing.

People were able to make choices about their care and the service operated in line with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. People told us they were treated with respect by staff and that staff were friendly and caring.

Staff had a good understanding of how to promote people's dignity, privacy and independence.

Is the service responsive?

Good

The service was responsive. Care plans were in place which set out how to meet people's needs in a personalised manner. Care plans were subject to regular review.

The service had a complaints procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led. People and staff told us they found senior staff to be supportive and helpful. There was a registered manager in place.

Systems were in place for monitoring the quality of care and support at the service. Some of these included seeking the views of people using the service.

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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.

This inspection took place on the 7 December 2017 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 in.

The inspection was carried out by an inspector 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.

Before the inspection we reviewed the information we already held about this service. This included details of its registration, previous inspection reports and any notifications the provider had sent us. Notifications are details of significant events that the provider is legally obliged to inform the Care Quality Commission about. Prior to 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 improvements they plan to make. We contacted the local authority with responsibility for commissioning care from the service to seek their views.

During the inspection we spoke by telephone with five people who used the service and seven relatives. We spoke with six staff including the registered manager, care coordinator, administrator and three care assistants. We also spoke with a consultant the service was employing at the time of our inspection in the role of quality assurance manager. We examined the care records relating to ten people including care plans, risk assessments and medicine records. We checked eight sets of staff recruitment, training and supervision records and looked at the quality assurance systems at the service. We sampled various policies and procedures including the complaints, safeguarding adults and medicines policies.

Good

Is the service safe?

Our findings

At the previous inspection of this service in July 2016 we found there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff were often late to appointments with people which meant they did not receive personal care and support with medicines at the time required. During this inspection we found this issue had been addressed. The service had introduced an electronic monitoring system. Each staff member was provided with a phone which they used to check in and out each time they went to a person's house to provide support. This information was captured on the IT systems used so the service was able to check that staff arrived on time and stayed for the full amount of time allotted. People we spoke with told us staff punctuality had improved. One person said, "They have to use their phones and their book to check in and out, the office check on them." Another person said, "Their timings have got better. They have to scan the book for when they come and go."

Staff told us they had enough time to get between clients and they were usually on time. They told us if they were running late they phoned to let the office know so that the office could in turn inform the person of the situation. One member of staff said, "I always ring them and if I can't get through I ring my manager just to let them know I'm running late." Another member of staff said, "I usually make it on time and I have never been that late."

The service had robust staff recruitment processes in place. People told us and records confirmed that the service carried out various checks on staff before they commenced working with people. One member of staff said, "I did have a DBS already but they wouldn't take it, they did their own." DBS stands for Disclosure and Barring Service and is a check to see if staff have any criminal convictions or are on any list that bars them from working with vulnerable adults.

Records showed checks carried out on staff included criminal records checks, employment references and proof of identification. We noted that staff application forms asked prospective staff to provide details of their age and marital status. This was potentially discriminatory practice with regards to equality and diversity. We discussed this with the registered manager who told us they would amend the application form so it no longer requested this information.

The service had systems in place help protect people from the risk of abuse. There was a safeguarding adult's policy in place which made clear the services responsibility for reporting any allegations of abuse to the local authority and the Care Quality Commission (CQC). Records confirmed that the procedure had been followed. The service also had a whistle blowing policy which made clear staff had the right to whistle bow to outside agencies such as the CQC. Staff had undertaken training about safeguarding adults and were aware of their responsibility for reporting any allegations. One member of staff said, if they suspected abuse, "I would report it to my manager straight away and write it all down."

Where the service spent money on behalf of people records and receipts were maintained. These were periodically checked by a senior member of staff which meant the service had taken steps to reduce the risk of financial abuse occurring.

The service carried out risk assessments on people. These included information about the risks people faced and about what action to take to mitigate those risks. Risk assessments covered risks associated with moving and handling, medicines and the physical environment. The registered manager said, "We will look at the environment and do a risk assessment as a result." Records showed risk assessment about the environment looked at if there were any trip hazards or issues with lighting in people's homes. Risk assessments were personalised around people's individual needs. For example, the risk assessment on mobility for one person stated, "Carers to make sure that person always mobilizes with their Zimmer frame. Make sure that when they use the stair lift the Zimmer frame is nearby within reach. Carers to make sure person puts the safety belt on and that there are no obstructions on the stairs." The registered manager told us the service did not use any form of physical restraint when working with people and care staff confirmed this was the case.

People told us they were supported with their medicines. One person said, "They always prompt me to take my medicines which is good as I do forget sometimes." The service had a medicines policy in place which covered the recording and administration of medicines. It stated that staff had to undertake training before they were able to administer medicines and records confirmed this was done. Medicine administration record charts were in place where the service supported people to take medicines and these contained details of each medicine to be given. Staff signed the charts after each administration so there was a clear record that the person had received their medicine. The medicine charts were checked by a senior member of staff to ensure they were completed correctly once they had been completed. We saw that where issues were found they were addressed with the relevant staff member, for example, one staff member had completed charts using blue ink rather than the required black. We looked at some medicine charts and found they were accurate and up to date.

Staff were provided with gloves, aprons and hand gel to help prevent the spread of infection. Staff were aware they had to use the protective clothing whenever giving personal care. One member of staff said, "I wash my hands, wear gloves and aprons, use my sanitizing gel." Staff said they collected the protective clothing from the office and they always had a sufficient supply.

Where things went wrong the service took action to help ensure the same mistakes were not repeated. For example, in February 2017 a staff member went to an appointment at a person's home and could not gain entry and no one answered the door. The staff member did not report this. The person was later found to have died. The service took action about this which included disciplinary action against the relevant staff member. An investigation was carried out by the service which found staff were not always following proper procedure when they could not gain entry to a person's home. As a result all staff were re-trained in this issue and staff we spoke with had a good understanding of what to do in such circumstances. As previously discussed the service also took action as a result of concerns about persistent lateness by introducing a staff monitoring system so the service was able to tell what time staff arrived for appointments.

Records were also maintained of accidents and incidents and these were used to learn lessons to try to ensure similar incidents did not occur For example, one person sustained a minor injury when receiving care from a staff member wearing a bracelet which caused a bruise. The individual staff member was subject to disciplinary procedures and the wider issue was discussed with all staff during team meetings. This showed where things went wrong the service took steps to address issues.

Good

Is the service effective?

Our findings

People told us they were involved in the assessment process. One person said, "The initial assessment was good. It does what it says on the tin." A relative told us, "They included [person] in the assessment and then left me a book but I've never looked in it. They asked if [person] wanted a man or a lady [care staff]."

People's needs were assessed before the provision of care. The registered manager told us after receiving an initial referral they made contact with the person's family so they were able to be involved in the assessment process. They then met with the person and their family to carry out an assessment of their needs. The registered manager told us, "The assessment will look at the needs of the clients and looks at the plan sent from the local authority." The purpose of the assessment was to determine what the person's needs were and if the service was able to meet those needs. The registered manager told us on occasions they had declined people because they were unable to meet their needs. For example, one person required the support of three staff at a time and the service was not able to provide this. Records of assessments showed they included information about what was important to the person and what they wanted support with. Assessments recorded people's ethnicity, preferred language and religion. They did not ask about people's sexuality including if people were Lesbian, Gay, Bisexual or Transgender (LGBT). We discussed this with the registered manager who told us they would amend the assessment form to include this detail, and added that the service did not discriminate against people on the grounds of their sexuality.

The service supported staff to develop skills and knowledge to support them in their job. New staff undertook an induction programme that included classroom based training and shadowing experienced members of staff to learn how to support individuals. A newly recruited member of staff told us, "I went out shadowing with a couple of staff for about a week so they could show me the care people needed." New staff also completed the Care Certificate, this is a training programme designed specifically for staff who are new to working in the care sector. Records showed staff continued to receive on-going training which included training about moving and handing, food hygiene, health and safety, dementia care, safeguarding and the role of the carer. Staff told us they were happy with the training they got. One member of staff said, "I've done training for using the hoist, health and safety, medication, a lot of things. I'm doing a course about care."

Staff had regular one to one supervision meetings with a senior member of staff. Staff said they found this helpful. One staff member said of their supervision, "Supervisions are when we come here [to the office] and we talk about health and safety and medicines, making sure we are doing everything properly. If we have any concerns we let them know." Records showed supervision included discussions about good practice issues, for example, in relation to medicines and safeguarding as well as discussions about issues relating to people using the service.

People told us they were supported with their meal preparation. One person said, "Whole point is to check I'm OK and that I have something to eat and they seem to understand the importance of that with my condition." Care plans included information about supporting people with food preparation which indicated people were given a choice about what they ate and drank. For example, the care plans for one

person stated, "Carers are to make me a sandwich of my choice, cover with foil and leave in the kitchen for my lunch."

Staff were aware of what action to take if people were unwell or had an accident. They told us they would contact people's GP or phone for an ambulance as necessary and inform people's next of kin. A member of staff told us, "I would ring an ambulance straight away and wait with them until the ambulance arrived." We saw that care plans included contact details of GP's and relatives. Records showed the service worked with other agencies to promote people's health. For example, one person's mobility had deteriorated and the service had consequently made a referral to the occupational therapy service. For another person we saw an email from the service to the commissioning local authority which stated, "The service user has a life line pendant which interferes with their oxygen nasal cannula, please can you arrange for a wrist alarm."

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 had signed consent forms. These included various elements such as consent to the service sharing information about the person with relevant persons and consenting to senior staff to observe care for the purposes of monitoring and training staff. The person was able to choose which if any of the individual items they consented to. Care plans had information about consent to care. For example, the care plan for one person stated, "I would like my carers to offer me choices and respect my opinion, gaining my consent before doing any tasks." Family were involved in making decisions where people lacked capacity. A member of staff told us, [Person] has a lot of notes that their family have put up about things they like to eat." This meant the service was able to support people in line with their wishes.

Good

Is the service caring?

Our findings

People told us staff were caring and acted in a kind way. One person said, "They have got to know me, the regular ones ask about friends and family. They are all caring and respectful, I think they have a regard for older people." A relative said, "She's a brilliant lady [staff member], 100%. I like to think of her as a friend."

Care plans included information about the person's likes and dislikes. For example, the care plan for one person stated, "I enjoy reading newspapers, watching television and using the computer." By including such information about the person this helped staff to get a good understanding of them which in turn helped them to develop good relationships with people.

The registered manager told us they sought to match staff to work with people they would be most suited to work with. They said, "When matching people with carers we take into account their cultural needs. We have carers who speak [specified language] and people who speak that so I place them together. Other people are [specified religion] and we have staff of that religion. It works well because they understand what they like to eat." The registered manager told us one person had not been satisfied with their staff because they did not know how to cook food of their culture, so a different staff member was provided who shared the person's culture and was able to produce food to the person's liking.

Staff had a good understanding of how to support people in a way that promoted their dignity and privacy. For example, one member of staff told us, "I always ask them first, like I would say, 'is it ok if I change your pad?' never do it without asking. I always shut the curtains and the doors." The same staff member also said, "I do [wash] the top half and put a towel round the bottom half." Another member of staff said, "In case there is a risk of fall I have to be in the toilet with some of them but I don't watch them, I just tell them to shout when they are ready." A third member of staff told us, "I talk a lot to make them comfortable. Always ask them to make sure it's ok to start washing and dressing, I always get permission first. Always make sure the doors are closed and the windows shut, when I'm washing them I cover them with a towel to give them their privacy." The service had a confidentiality policy in place which made clear staff could only share information about people with relevant persons where they were authorised to do so. This helped to promote people's confidentiality and privacy.

People were supported to maintain their independence. Staff told us the supported people to manage as much of their care as they could themselves. One member of staff said, "I always ask them if they would like to do it themselves. When I give [person] a shower they like to dry their bottom half and me to do the top." Another staff member said, "I always ask to see if they are independent, to let them do what they can themselves." A relative told us, "They do encourage [person] to be independent and that has helped their recovery."

Care plans included information about peoples communication needs. For example, the care plan for one person sated, "I can communicate well but am very hard of hearing. Carers are to speak clearly and loudly and to speak facing me so I can gather what they are saying."

Good

Is the service responsive?

Our findings

People told us they were involved in developing their care plan. One person said, "They came to the house to sort the care plan and they have been a couple of times as things have developed."

Care plans were in place for people. These were based on the initial assessment and on-going observation and discussions with the person and their family. The registered manager said of the care planning process, "We are looking at the wishes of the client, things that the person wants us to do for them." Records showed care plans covered needs associated with personal care, medicines, communication, continence management, eating and drinking, emotional wellbeing and likes and dislikes. Care plans included personalised information based around the needs of the individual. For example, the care plan for one person stated, "I have a history of depression and I am under the Older Adults Mental Health Team. I would appreciate it if carers kept an eye on me and raised any concerns." The care plan for another person stated, "Twice a week I would like a bath. Staff are to cover my ankle with clingfilm as there is a pressure sore there."

Staff we spoke with had a good understanding of the individual needs of the people they supported and told us they read people's care plans. One staff member said, "If I get a new client I always look through the care plan."

Care plans were subject to regular review. This meant they were able to reflect people's needs as they changed over time. The registered manager told us, "We do that [review the care plans] every six months unless the care needs change. If there is an incident or something like that we review the care plan again." Daily records were maintained of the care provided at each visit which meant it was possible to monitor the support provided on an on-going basis.

People told us they knew how to make complaints and when they raised issues things had been addressed. One person said, "I complained about one staff. She came back to work with a nasty cold and I didn't want her here. She'd also been late and didn't have any common sense to pick things up. They didn't send her anymore."

The service had a complaints procedure which included timescales for responding to complaints received and details of who people could complain to if they were not satisfied with the response from the service. Each person was provided with their own copy of the complaints procedure when they commenced using the service so that it was accessible to them.

Records were maintained of compliments. A person who used the service wrote, "It's a great team, individual care and very thorough. The lady that attends me is great." Another person wrote, "[Staff member] is a wonderful carer. She is efficient, polite, and reliable. She always treats me with respect and kindness." A relative wrote, "I am very happy with the service for my [family member]. I cannot fault it at all."

The registered manager told us the service was not providing support to people with end of life care at the time of our inspection.

Good

Is the service well-led?

Our findings

At the previous inspection of this service in July 2016 we found they were in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because they had failed to notify the Care Quality Commission (CQC) of allegations of abuse. During this inspection we found the service had addressed this issue. CQC had been notified of allegations of abuse along with other significant events the provider was legally obliged to inform CQC of.

At the previous inspection of the service we found there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because auditing systems were not been implemented. Specifically, we found medicine records and daily care records were not audited. During this inspection we found this issue had been addressed and the service carried out regular audits of medicine and care records.

People spoke positively about the registered manager and told us they were asked about their views. One person said, "I can rely on the manager and I know them well." Another person said, "I feel I can call them, I'm quite happy." A third person said, "A lady came to see me to ask how things were and that's been followed up by phone calls."

Staff spoke positively about the working culture of the service and of the registered manager. One member of staff told us, [Registered manager] is excellent. If I have any problems they will sort it out straight away." Another member of staff said of the registered manager, "Very caring, very professional. They are a good manager, fair and 100% approachable." A third staff member said, "[Registered manager] is on the ball, they are very supportive." The same staff member added, "I'm really enjoying it, it's a lovely company to work for."

The service had an out of hour's on-call system which meant senior staff were always available for advice. Staff told us the on-call system worked effectively. One member of staff said, "I always get through to them [when phoning the on-call umber]."

The service employed an external person to provide support with quality assurance issues. They told us they carried out audits of risk assessments and care plans to ensure they were person centred, telling us, "If they [care plans] say the person needs personal care what does that mean, do they need a bath or a wash, what can they do for themselves? That kind of thing." Records showed that care plans were person centred. They also told us if people raised concerns they went and met with them to try to address issues. For example, one person was concerned that they were not getting the care they wanted and after meeting with them the care plan was reviewed to reflect their needs.

Staff told us and records confirmed that the service held regular staff meetings. This gave the management the opportunity to share relevant information and provided all staff the chance to share good practice and discuss any issues of importance to them. One member of staff aid, "At staff meetings we go through the clients, medicine charts, if we have any problems with other areas." Another member of staff said of team

meetings, "We get together, discuss things we feel strongly about, anything that comes up really." Minutes of team meetings showed they included discussions about record keeping, what to do if a staff member could not gain access to a person's home, good practice when interacting with people and staff rota issues.

Spot checks were carried out. These involved a senior member of staff doing an unannounced check at a person's home when care was provided. A member of staff said, "One of the office staff did a spot check. They watched what I was doing to make sure I was doing it right." The registered manager said, "Spot checks are where we go to clients houses, most of them are unannounced. We are looking at how the communication flows between the carer and our client. We need to make sure they are protecting people's dignity and respecting their homes." Records confirmed spot checks took place.

The registered manager told us the service was in the process of conducting a survey of people who used the service at the time of our inspection. Surveys had been sent out to people, some had been returned but the deadline had not expired for this and they were still waiting for others. They told us once all replies were returned they would analyse the data and produce an action plan where issues were identified that needed to be addressed. We looked at the surveys that had been completed and returned and found they contained positive feedback.

Senior staff met with people in their homes to check things were going well. The care coordinator told us, "We do customer reviews, we go out there and check everything is ok, check they are happy with the times of visits, that there's no change needed to the care plan, going through the complaints procedure so they know how to make a complaint." Records of customer reviews showed they included asking people if staff stayed for the full duration of their visit and carried out all required tasks, if they wore protective clothing and if people felt they had good communication with the office staff. In addition to the customer reviews the service carried out telephone monitoring of people. The registered manager said, "The point of the phone monitoring is to hear from your clients, if they are happy, if there is anything that is not working for them." Records confirmed regular phone monitoring took place

The service carried out various checks and audits and took action to address issues identified, for example, daily records were audited and it was found one staff member had not been completing these properly. This was discussed with the relevant staff member and improvements were made. The staff member was given training on record keeping and closely monitored for a time until the service was happy with the standard of record keeping by the staff member.

The service worked with other agencies to help improve and inform practice. For example, the registered manager attended a 'Providers Forum' that was facilitated by the local authority in which the service was located. The forum was quarterly and open to care providers within the borough and attended by representatives of the local authority. The registered manager told us, "In these meetings we will disuses problems and talk about the solutions."