Locala Homecare Limited

Beckside Court

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 10 August 2016 and was announced. The service had been registered with the Care Quality Commission since May 2013 and had previously been inspected during November 2013, when the service was found to be compliant in all areas inspected.

Locala homecare of Beckside Court provides domiciliary care services to people in their own homes. The people who receive these services have a wide range of needs.

The service had a registered manager in post at the time of our 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.

People and their relatives told us they felt safe and staff had received safeguarding training in order to keep people safe. There were enough staff to meet people's needs with a regular, consistent staff team and there were robust recruitment practices in place, which meant staff had been recruited safely. Risks to people and staff had been assessed and reduced where possible.

The recording of the administration of medicines had not been accurate. Records did not provide a clear and accurate account of the medicines people had been administered by staff. This had been addressed prior to the inspection and a review of medicines management was taking place.

People received effective care and support to meet their care and support needs. People and their relatives felt staff had the necessary skills and training to provide effective care and support. Staff told us they felt supported and we saw staff had received induction and training. Staff received ongoing supervision and appraisal.

We saw from the care files we reviewed consent had been sought and obtained from people, prior to their care and support being provided.

People and the relatives we spoke with told us staff were caring. The staff we spoke with were enthusiastic and were driven to provide good quality care. Staff told us how they respected people's privacy and dignity and the people we spoke with confirmed this. People were encouraged to maintain their independence.

Care support plans were detailed and personalised, taking into account people's choices and preferences. People had been involved in their care planning and told us they felt they could make their own choices. Some people received support to continue enjoying activities that were important to them, in the local community.

All of the people, relatives and staff we asked told us they felt the service was well led. Regular quality

assurance checks and audits took place. Staff felt supported and people felt able to contact the office in the knowledge they would be listened to.

Due to business growth, recent changes had taken place in terms of the structure of the organisation. People and staff felt this was effective. The head of operations was supported by a wider team and had developed a growth strategy to support the growing organisation.

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 told us they felt safe and staff understood signs of potential abuse and could explain what action they would take if they had any concerns.

Risk assessments had been completed and measures were in place to reduce risks to people and staff.

Staff had been recruited safely and staffing was appropriate to meet the needs of the people who used the service.

Is the service effective?

Good

The service was effective.

Staff received an induction and people told us they felt staff were skilled and well-trained.

Consent was obtained from people in relation to the care and support provided.

People received support in order to have their nutritional and hydration needs met.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were caring. Staff were motivated to provide good quality care.

People's privacy and dignity were respected.

Confidentiality was respected.

Is the service responsive?

Good

The service was responsive.

People told us the service was flexible to meet their needs.

Care plans were detailed and personalised, enabling people to receive support that was appropriate for their individual needs and preferences.

Complaints were well managed and responded to in line with policy, resulting in a satisfactory outcome.

Is the service well-led?

Good

The service was well led.

People and staff told us they felt the service was well led.

Regular quality assurance checks were in place in order to continually improve the service.

There was an open and transparent culture and the head of operations and team were receptive to feedback and keen to drive continuous improvements.

Beckside Court

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 10 August 2016, with follow up telephone calls being made to staff and people who used the service, and their relatives where appropriate, on 16 August 2016. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure someone would be in the office. The inspection was carried out by an adult social care inspector. Prior to our inspection, we looked at the information we held about the service and considered information we had received from third parties or other agencies.

The registered provided had 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 used this information to help inform and plan our inspection.

As part of our inspection we looked at five care plans and associated records such as daily notes and medication administration records, four staff recruitment files, training records, records relating to quality assurance and audits and policies and procedures. We spoke with five people who used the service and four relatives of people who used the service. We also spoke with four members of care staff, a care coordinator, the homecare development manager, the human resources business partner, the head of operations and the registered manager.

Good

Is the service safe?

Our findings

We asked people whether they felt safe using the service. One person said, "Safe? Sure, yes." Another said, "They're mostly on time. Only if they've had an emergency on a previous visit are they late. Then they apologise." A further person said, "They're on time. They do their jobs well and I feel safe."

A family member we spoke with said, "There have only been a couple of occasions when they've been running late."

There was a clear, up to date, safeguarding policy. Staff had been trained and understood appropriate policies and procedures in relation to safeguarding people. Staff were able to demonstrate a good understanding of different types of abuse and were aware of signs that may indicate someone living in their own home, or in the community, may be at risk. Staff and the head of operations were able to explain what they would do if they had any concerns that people were at risk of abuse and there was a designated safeguarding lead person. This meant people who used the service were protected from the risk of abuse, because the provider had a robust policy in relation to safeguarding and staff were aware of this.

The head of operations told us individual risks to people and staff were assessed, as well as environmental risks, and measures were then put into place to reduce risks. We saw potential hazards in people's homes were identified such as gas and electrical appliances, fire safety and escape routes. Individual risks regarding falls, medication, moving and handling were also assessed. Having risk assessments in place helped to ensure people could be encouraged to be as independent as possible whilst associated risks were minimised.

Staff were given clear instructions on how to safely assist people to move. We saw moving and handling risk assessments were in place which identified the type of hoist which should be used, the make, type and size of sling to use as well as method of application. A pictorial guide was also included as well as written instructions. This helped to ensure risks were reduced and staff were given appropriate information to assist people to move safely.

In addition to assessing risks to people who used the service, risks to staff were considered and measures were put into place to reduce risks. A staff member we spoke with told us risks to people and to staff were assessed and they felt safe working for the organisation. An example of this was a person who lived at the end of a single way track. It was decided, in order to reduce risks to staff, that two staff would attend this person's home. Time was allocated for travelling between different people's homes which reduced the risk of carers feeling pressured and rushed.

The head of operations was aware of the need to ensure equipment was well maintained and serviced. We saw equipment was serviced. In one of the care plans we sampled, there was an equipment service schedule, which identified when the item of equipment was next due for service. The next service date was December 2016. This helped to keep people and staff safe and showed steps had been taken to ensure the equipment was safe to use.

Accidents and incidents were logged and analysed. We saw actions were taken when possible, to reduce risks of accidents. There was an on call system in place, which meant staff and people were able to contact a more senior person for advice, out of hours, in the event of an accident or an emergency. The staff we spoke with confirmed the on call telephone was answered when they had needed to use this.

There were enough staff to meet people's needs. The head of operations had recognised additional staff were required because the business had grown significantly in recent months. A development manager and office manager had recently been recruited and four senior carers were being recruited. The senior carers would provide care and support to people but they would have additional capacity to assist carers with any complex issues. In addition there were two field supervisors who each specialised in different areas such as medication and quality assurance. There were approximately 50 care staff. The people and staff we spoke with told us they were happy with staffing levels and they felt there was continuity of care. One person said, "There are usually two or three of them [staff]. I know them." A staff member told us, "There are enough staff. We get the odd call requesting cover but not loads. They seem to have quite a lot of staff." The rotas we inspected showed there was continuity of care where this was possible.

As the business had grown, the head of operations had identified a more robust system would be required, for identifying potential late calls. A new system was being introduced whereby people's care plans would contain a microchip and staff would swipe the microchip with their mobile device which would then alert the coordinators as to whether staff had arrived at a person's home. This would reduce the risk of calls being missed or late and meant that action would be able to be taken promptly. This new system was due to be introduced in the weeks following the inspection. The people we spoke with told us staff were rarely or never late and there were no missed calls.

We inspected four staff recruitment files. We found safe recruitment practices had been followed. For example, the registered manager ensured reference checks had been completed and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

Staff disciplinary policies were in place and these were followed where necessary. For example, the head of operations told us a staff member had been suspended from their duties in order that allegations could be investigated. The staff member returned to their duties following the investigation when it was found the staff member had not acted inappropriately. This showed appropriate actions were taken when there were allegations a staff member's conduct fell below that which was required.

We looked at how medicines were managed and administered. The head of operations told us staff prompted and sometimes administered medication. Staff had received training in order to provide this level of support to people.

We saw medication risk assessments were in place. Consideration had been given regarding whether people could manage their own medicines in terms of storage, ability to swallow, reading labels and removing capsules from containers for example.

We found inconsistencies and conflicting information in the recording of the administration of people's medicines. One of the records we sampled indicated, 'Medication self-administered,' but also, 'No medication prescribed for this time.' The daily log for one person stated 'Medication given,' but, 'Medication self-administered,' was indicated on the medication administration record (MAR). On another MAR we inspected, staff had used a symbol which was not indicated on the key so it was not possible to determine exactly what action had or had not been taken regarding medicines. Some days were blank and had not

been completed on the MAR so, again, it was not possible to determine what action had been taken on these days. There were no protocols in place for PRN medicines, which are medicines administered 'as and when required.' Having PRN protocols in place assist staff to understand when a person may require their PRN medicine. This meant there was a risk that people were administered their medicines incorrectly.

Medicines management had been identified as an area for improvement prior to the inspection and we saw plans were in place to improve this. One of the field supervisors had received additional training and support to become a medication champion and was reviewing PRN protocols and MARs. New processes had recently been introduced to assess staff competency and we were shown examples of this. We saw meetings had been held and new improved MAR charts were being developed as a result. The medication champion had made links with the medicine management unit within the wider Locala Group. This showed steps had already been taken to improve the management and recording of medicines.

The organisation had a 'bare below the elbow' policy and staff were issued with uniforms, identification badges, reflective jackets and mobile phones. Staff had access to personal protective equipment (PPE) and people told us staff wore gloves and aprons when they were assisting people with personal care. This helped to reduce the risk of the spread of infection.

Good

Is the service effective?

Our findings

When we asked people whether they felt staff were effective, one person told us, "They know what they're doing."

A family member we spoke with told us staff used hoisting equipment to assist their relative. We were told, "Staff know what they're doing. They've been trained." Another family member told us they felt staff had the skills and experience to provide effective care. A further family member said, "Their skills and experience? Oh, excellent."

All the staff we asked confirmed they felt they received adequate induction for their role, which had included shadowing more experienced members of staff. New staff were undertaking the Care Certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. The head of operations told us the vision was for all staff to complete the Care Certificate because they felt all staff could benefit from this in terms of staff development and training. Some staff were also being supported to complete their national vocational qualification (NVQ) level 2. A staff member we spoke with told us, "The training's really good. If I feel I'm lacking in any areas they'll arrange training. I feel really supported."

Staff had received supervision regularly and records of staff supervision showed items discussed included how staff felt about their work, whether staff felt overworked and whether staff felt they needed further training. Annual appraisals included examining staff objectives, strengths, skills, abilities, development needs and management feedback. This showed staff were given the opportunity to reflect on their practice and their training needs were considered regularly.

We saw staff competence was regularly monitored through quality assurance processes and the staff we spoke with told us they felt supported. We saw unannounced quality checks had taken place to ensure staff were performing their duties effectively. Checks included whether staff arrived on time, were wearing uniform and identification badges, whether staff followed the person's care plan and correct procedures.

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. The head of operations told us everyone who received care and support had capacity to make decisions and give consent in relation to the support they received. However, the head of operations understood their responsibilities, under the Mental Capacity Act, should they have felt anyone lacked capacity. Staff also understood the principles of the MCA, and this was a module of the mandatory training. All of the care plans we sampled showed people

had capacity to make their own decisions in relation to their care and support.

We saw people had consented to the care and support being provided by signing the relevant documentation. Where people had consented but were unable to sign, this was appropriately recorded.

Some people received support to maintain their nutritional and hydration needs. Staff told us they offered people choices regarding the food and meals they wanted. A person we spoke with said, "They prepare meals okay. I choose what I want." Detailed information was included in care plans where necessary in order to provide care staff with sufficient information to enable safe care and support to be provided. For example, one person required all fluids to be thickened, due to a risk of choking. The care plan contained additional information and provided staff with directions on exactly how to thicken the fluid.

The head of operations told us people were assisted to access health care, through a single point of contact for Locala. A local community matron was attending the next staff team meeting to share information on the services they provided and to share information regarding how staff could make appropriate referrals.

Good

Is the service caring?

Our findings

We asked people and their relatives whether they felt support staff were caring. One person said, "It's a good service. The carers are nice to you." Another person told us, "They're all absolutely excellent." A further person told us, "Aw, they're beautiful. They really help me."

A relative told us, "Overall we're very pleased. We like them [the carers]." A further relative told us, "I have nothing negative to say. They respect [Name of person]'s privacy and really take care. Staff are professional and they're easy to get along with."

A person told us staff respected privacy and dignity. Another person told us, "I feel in control even though they're providing care. They respect my privacy."

Comments from a telephone survey undertaken during 2016 included, 'Staff very friendly,' and, 'I am really happy with the service. My relative gets on well with the carers.'

We sampled a service user quarterly survey and saw the comments, 'They always treat me with dignity and respect and respect my decisions. They do what they are supposed to do and never force me to have what I do not want.'

Staff told us about the ways in which they promoted privacy and dignity. One member of staff told us, "I close curtains and make sure people stay covered if I'm helping with personal care."

A staff member told us they were aware of the importance of encouraging independence and said, "I'll always ask the person if they want to try and wash themselves first, before helping them. I try to encourage people to be independent. That's what we do."

Confidential information was kept secure. Staffs' mobile devices were password protected and would automatically shut down if not in use, requiring the password to be re-entered. This helped to ensure private and confidential information about people was respected and securely stored.

Care plans contained information relating to 'Do not attempt cardio pulmonary resuscitation' (DNACPR) orders and indicated whether or not there was one in place. Staff understood the relevance of this, which meant staff were aware of people's wishes, in terms of whether they should be resuscitated.

End of life care was an area both the head of operations and registered manager told us they wished to improve and enhance. Staff had received end of life care training. We saw end of life training included understanding palliative care, understanding of illnesses that require end of life care, communication skills, empathy, active listening, recognising final stage of end of life care and care after death. The head of operations had given consideration to further training at a local college, who were offering national vocational qualifications in end of life care, although staff had not yet enrolled on this training.

We saw a letter had been sent to the organisation, which stated, 'The last few months of [Name]'s life were made significantly more bearable by the support provided by Locala carers.'

Good

Is the service responsive?

Our findings

A person told us, "I don't have anything to complain about at all. But if I did, I would let them know and I'm sure they'd sort it."

We asked people whether they felt the service was flexible to their needs. One person told us, "One of them [carers] did an extra visit on [a very special] day to help get me ready, as an extra call." This person was very pleased with the service. This showed the organisation was flexible and adapted to people's individual needs and requests.

We sampled five care plans. Care plans contained an audit check sheet which showed relevant details had been completed such as key contacts, personal goals, statement of consent, risk assessments and mental capacity assessments.

The care plans we sampled were up to date and included information regarding people's needs and the level of support they required. Additional information regarding people's likes and dislikes and goals were also included. People had been involved in developing their goals and care plans. A member of staff who was involved in developing care plans told us, "I ask people what they want. They are the ones paying for the care." Plans were written in a person centred manner and contained information to provide staff with information about the person. For example, one plan stated, 'I talk to my friends on the phone each day. I am a positive person and I like to keep myself busy.' This showed people receiving the service had been involved in developing their care and support plans.

Detailed information was contained in support plans. For example, one plan we sampled stated, 'On arrival please use the key safe to enter my home. When you have let yourself in, shout to say hello. I will be upstairs in my bedroom and I would like assistance to go to the bathroom.' This level of detail enabled staff to provide personalised care and support.

Care plans contained a 'Daily Living' section which included details regarding the individual's background, family life, likes, interests and important things to the person. Including personal information such as this in care plans helps staff to understand more about the person they are supporting.

Care and support staff completed comprehensive daily notes which were signed and dated. This helped to ensure records and information were shared appropriately and helped to ensure continuity of care and support.

A family member told us a member of staff had arrived to provide support to their relative. The member of staff had not supported their relative for, "A while," but was assisting because the regular staff were on leave. However, the carer remembered what drink the person liked to have on an evening and asked the person if this remained their choice. The family member told us, "My [Name of relative] was so pleased that the carer had remembered."

The head of operations told us people's care plans were reviewed annually or sooner if required. Care needs were discussed regularly at meetings and if people's needs changed they were reviewed. All of the care plans we sampled were up to date, with recent reviews being held.

Some people received care and support in order to access activities that were important to them. For example, one person was supported to maintain their interest in roller skating at a local facility. This showed people received support to maintain contacts and interests in the local community which helps to reduce the risk of people being socially isolated.

None of the people we spoke with had felt the need to complain about the service. However, everyone we spoke with told us they would feel comfortable and able to complain and they felt confident they would be listened to. The head of operations advised they had received one formal complaint. The complainant had been responded to in line with policy and received an apology. Staff learning had resulted from this.

Good

Is the service well-led?

Our findings

The service had a registered manager in post, who was registered with the Care Quality Commission. However, the business had grown rapidly and the registered manager explained they had delegated the day to day management of the service to the head of operations. The registered manager and head of operations told us they recognised it would be appropriate for the head of operations to apply to become registered manager with the CQC and this process would be ongoing. The registered manager sat on the board and had a good oversight of the business, working with the head of operations.

The registered office for the service was Beckside Court. The head of operations explained that, although Beckside Court was the head office and some historical documents and records were kept there, the day to day running of the service took place from Mill Hill Health Centre. We discussed with the head of operations the requirements of registration and advised the correct address needed to be registered for the service.

A person who received care and support told us they felt the organisation was well led and they were happy with the overall management of the service.

All of the staff we asked told us they felt supported in their roles. A member of staff told us, "I feel supported. There's a good support system. I feel supported by [head of operations]." Another staff member told us they had received support through some personal issues.

We asked staff whether they felt the organisation was well led. A member of staff told us, "When I first joined it seemed unsettled. But the structure's changed and it's improved vastly. The coordinators are more 'on the ball'." A further staff member told us, "The coordinators are more organised now, in the last few months."

One member of staff said, "I've worked for a few care companies now and this is the only one I've stayed at." Another staff member told us, "It's a hundred times better than other companies."

We were told, "[Name]'s in charge. You can always raise anything. There are staff meetings regularly and they keep us informed. I've worked for three different care companies and this is the best."

A member of staff we spoke with told us they were aware the organisation had grown rapidly but added, "I don't feel quality of care has reduced. They've recruited and sent new staff out shadowing."

The business had significantly grown within the last six months. Therefore, the structure had recently changed to reflect this and further posts were being advertised. There was a clear structure in place with clear lines of responsibility. The head of operations had developed a homecare growth strategy and this was updated regularly. This helped to ensure measures were in place to support the growing organisation.

Risks to the organisation were assessed and considered by the head of operations. These included risks associated with contracts, finances, quality of care, staff recruitment and structure of the organisation for example. Actions required to reduce the risks were given consideration and actioned where possible, in

order to reduce organisational risks. This information was shared with the wider Locala group.

The registered manager explained the vision was to work with commissioners to provide more effective home care packages, enabling people, which may then in turn reduce hospital readmissions and promote independence.

The head of operations worked with the local hospice, who provided an out of hour's service. There was a service level agreement in place. Training in some areas was also delivered in collaboration with the local hospice. This showed the head of operations was developing partnerships with other organisations. The head of operations told us the senior coordinator sat on the local Dementia Care Group which different local partners attended, to consider the needs of people living with dementia. The head of operations had identified the benefits of support networks and had recently attended a national health and social care conference. Attending national events such as these enable good practice to be shared.

The head of operations told us they had begun to make links with a local volunteer group which offered befriending services to people in the community. This would enable referrals to be made to the volunteer group if Locala staff identified people in the community who may benefit from their services.

People were asked for their views in relation to the service and the support they received. We saw quality assurance questionnaires were sent to people and some people were contacted by telephone in order to seek their views. This showed consideration was given in the most appropriate format to enable people to provide feedback. We saw results from the questionnaires were shared with the board of the organisation and this resulted in action plans and actions were taken. One of the surveys identified people felt they did not see 'Office staff' frequently, so it was arranged for office staff to undertake the next face to face quality assurance visits. A telephone survey had taken place during June 2016, during which mostly positive feedback was received. Where any concerns were raised, we could see these were addressed and other health professionals were contacted as a result, such as district nurses.

The head of operations had set up a family forum and invited family members to attend. A terms of reference for this forum was being drawn up and it was decided the frequency of meetings would be every four months. We saw records of a meeting, in which the head of operations had agreed to share the development plan for the organisation at the next meeting. This showed the head of operations was engaging with families and sharing information about the organisation.

We saw the Spring Newsletter that was sent to staff, which welcomed some new members of staff. Some carers were identified and recognised as, 'Carers of the Month.' This type of recognition can help to motivate staff and make staff feel valued. New business opportunities were shared in the newsletter and staff were informed of the organisation's commitment to ensuring all staff received care certificate training. The newsletter also shared positive feedback that had been received from people receiving support from the service.

We saw minutes from team meetings showed the head of operations had asked staff what they understood their job role to be. Staff had responded indicating their understanding of promoting and enabling independence and giving people choice in their care. In one of the team meetings it was recorded that a presentation on basic life support was delivered and carers completed a basic life support assessment. Meetings are an important part of a manager's responsibility in sharing information and coming to an informed view about the service and any developments.

We saw, when daily logs were returned to the office, an audit took place. These considered whether the log

had been correctly completed, whether the log reflected the tasks on the support plan, whether times and dates were completed and correct and whether the log had been signed by relevant staff for example. Actions resulted from this and we saw staff were addressed where necessary.

We looked at audits of MARs and found the same concerns had been raised throughout February, March, May and June of 2016 in relation to the recording of medicines. Although there had been a lack of action to address this prior to the inspection, we could see an email had been sent to staff in order to address this. Furthermore, the whole management of medicines was being reviewed and improved and we saw evidence this was ongoing.