Cross Keys Homes Limited

Kingfisher Domicillary Care

Inspection report

Kingfisher Court
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Peterborough
Cambridgeshire
PE2 8NZ

Tel: 01733396484

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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

Kingfisher Domicillary Care agency is registered to provide personal care to people living at home. The agency covers the city of Peterborough and neighbouring suburbs. At the time of our inspection there were 39 people using the agency.

This comprehensive inspection took place on 8 November 2016 and was announced. It was carried out by one inspector.

The provider is required, as part of their registration, to have a registered manager. A registered manager was in post at the time of our visit. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage a registered service. 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 were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the agency. People were supported to take their medicines as prescribed.

People were supported to eat and drink sufficient amounts of food and drink. They were also supported to access health care services if they needed this type of support

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. When people were assessed to lack mental capacity to make decisions about their care, this was carried out in their best interest. Staff members had an understanding of the application of the MCA. The provider was aware of the actions to take if a person required a DoLS application to be made, which were detailed in clear policy guidance.

People were looked after by staff who were trained and supported to do their job.

People were looked after by kind staff. People and their relatives were involved in the review of their or family members' individual care plans.

Care was provided based on people's individual needs. Continued improvement actions were in place to ensure that, when possible, people were looked after by regular staff. Staff stayed the duration of people's planned care visits. There was a process in place so that people's concerns and complaints were listened to and these were acted upon.

The registered manager had attended a number of training and development courses to enhance their managerial skills. There was a team of senior staff who supported care staff to look after people. Staff were

supported and managed to look after people in a safe way. Staff, people and their relatives were able to make suggestions and actions were taken, if these were needed.

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's individual needs were met by sufficient numbers of staff.

People were kept safe as there were recruitment systems in place. This was so that only suitable staff looked after people.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

People's rights were protected as the provider was acting in accordance with the principles of the MCA.

Staff were trained and supported to enable them to meet people's individual needs.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by kind staff.

People's rights to independence, privacy and dignity were valued and respected.

People were involved and included in making decisions about how they wanted to be looked after.

Is the service responsive?

Good

The service was responsive.

People's individual needs were met. Staff stayed the duration of the call which was in line with people's planned care.

The support provided by the care staff enabled people to remain living independently at home.

The provider had a complaints procedure in place which enabled people and their relatives to raise concerns which were dealt with appropriately.

Is the service well-led?

Good

The service was well-led.

People were enabled to make suggestions to improve the quality of their care and these were acted on if needed.

The provider operated an open culture in the management of the service.

Quality assurance systems were in place which ensured that people were being looked after in a safe way.

Kingfisher Domicillary Care

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 agency, and to provide a rating for the agency under the Care Act 2014.

This inspection took place on 8 November 2016 and was announced. It was carried out by one inspector.

The provider was given 24 hours' notice because the location provides a domicillary care agency; we needed to be sure that someone would be in.

Before the inspection we looked at all of the information that we had about the service. This included information from any notifications received by us. A notification is information about important events which the provider is required to send to us by law. Also before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the agency, what the agency does well and improvements they plan to make. In addition to this information we received also information from a local authority contracts and monitoring officer.

During the inspection we visited the agency office where we spoke with the registered manager; one team leader and four members of care staff. Via telephone calls we spoke with five people who used the agency and two people's relatives.

We looked at four people's care records; audits; minutes of staff meetings and records in relation to the management of staff.

Good

Is the service safe?

Our findings

People told us that they felt safe because staff treated them well. Often we heard people describing staff to be "kind" and "lovely." The provider had carried out a survey during 2016; all of the respondents said that they felt safe from the risk of harm.

We checked and found that arrangements were in place to keep people safe. The provider told us in their PIR that, before staff looked after people, they were trained in safeguarding people at risk. Staff were aware of their roles and responsibilities in keeping people safe from the risk of harm. They confirmed that they had attended training and were able to describe the types of harm that people might experience. Furthermore, the members of care staff were aware of whom to report to, should they suspect or witness such untoward incidents. They said that this would be to named members of the agency's management team or to the police or local safeguarding authority. One staff member said, "I would report it [concern] to the office [staff] or maybe even call 999 if I needed to." In addition to this understanding, staff members were able to describe the signs and symptoms that people might show if they were being harmed. One member of care staff said, "The person may not be talking. Could be marks on their body. When we look after the same people, we get to know them and they get to know us. They become more confident in talking with us. And that's when we would get to know if there are any changes [in the person's level of well-being]." People told us that they had information about who to contact if they felt unsafe. This information included an out-of-hours on-call system and the local authority contact number.

Staff were vetted to ensure that they were suitable to do their job. Information in the PIR stated, "All staff recruited are DBS [Disclosure and Barring Service (police checks)] checked, reference checks and eligibility to work in the UK, before delivering any care." The registered manager described how staff were recruited and what they were looking for in prospective staff. They said, "I look for someone who is honest and caring. At interview I ask them why they want the job and ask about their understanding of it." In addition to this information, required checks were taken out. Members of staff confirmed that these checks, which included two references - one of which was from their previous employer - and a satisfactory DBS check, were carried out before they started their induction training. The provider had a staff disciplinary procedure in place which was used in the event of staff failing to meet the [provider's] standards expected of them.

There were enough staff to provide people with the care that they needed and when they needed it. The provider told us in their PIR that, "Staff turnover has decreased over the last 12 months, staff retention and development has been a priority to enable us to provide a good quality service." People told us that the staff usually arrived on time and were not rushed to leave earlier than they should. One person said, "It does vary if they [care staff] arrive on time. But if there is a bit of a delay, they do tell me. This morning they were dead on time." Members of care staff said that if there was an unexpected delay - such as being held up in traffic - they would ring the person to explain and apologise. Electronically held records showed that this was the case.

The team leader told us that they and the registered manager covered shifts when there was unplanned sickness. Members of care staff also said that they covered extra shifts when asked. The team leader said,

"We have such a brilliant team. They go above and beyond to help out [in covering shifts.] "

Recruitment of new staff was on-going and this was described in the October 2016 staff meeting minutes. This record noted that three new staff had started and another was due to start later in the month. People told us that they were aware of this, because they did not always receive "regular" staff, but had other, new staff to look after them. However, they had no concerns about this. One person said, "There are so many of them [staff] but it doesn't bother me as they do their job."

Assessments of people's risks were in place and these were managed to reduce the level of risk. One person told us that they were at risk of falling. However, they said that members of care staff always made sure that their walking aids were kept in easy reach. They also told us that they were helped to have a shower and said, "Knowing that someone is there, makes me feel much safer than if I was on my own." Staff members were aware of managing people's assessed risks. These included, for example, having two staff at all times to support people with their moving and handling needs by means of a hoist and sling. Another risk was related to people's eating and drinking and the risk of choking. One member of care staff described step-by-step how they added a prescribed thickening agent to drinks. This was for people who had been assessed by health care professionals to be at risk of choking. Another member of care staff said, "One person does need help with eating and drinking. We give them drinks and make sure they are sat upright in bed, to take small amounts at a time."

People's security and safety of their homes were also assessed and measures were in place to manage the level of risk. One person told us that they had a key safe which staff used to gain entry to their home. They said, "There's a black box in my porch where the [door] key is and staff know the code." They added that staff always locked the door on leaving. One member of care staff described how they ensured the key codes were kept confidential when the key safe was not in use. They told us that when closing the key safe they "scrambled" the numbers so that they key code was not accessible to people who were not authorised to have such access.

Most of the people who we spoke with said that they were independent with the ordering and taking of their prescribed medicines. However, when they were helped by care staff with this, they were satisfied with how this was done. One relative said, "The carer [member of care staff] always makes sure that each tablet is given and [family member] has taken it. They check the chart [medicines administration record or MAR] before they give it [prescribed medicine] to my [family member]." People's individual MAR charts demonstrated that people were helped to take their medicines as prescribed. The provider told us in their PIR that staff were trained in "Medication Management". Members of care staff told us that they had attended such training. Furthermore, the care staff members told us that they had their practice of helping people with taking their prescribed medicines observed. This observation was carried out during 'spot checks' on staff members by senior members of the management team. Records of these observed assessments showed that staff were deemed competent to carry out this part of their role.

Good

Is the service effective?

Our findings

We checked to see how people's rights to make decisions about their care were being protected. People told us that they were involved in making decisions about their care. This included setting up their care plans and making day-to-day decisions. One relative told us that their family member was unable to make complex decisions although members of care staff respected their day-to-day decisions. This included, for example, decisions about the type and level of support with their personal care and eating and drinking.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in registered services are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the agency was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection no person was subject to an authorised DoLS. However, the provider had clear policy to give staff guidance. This was in relation to their roles and responsibilities and those of external agencies and legislative bodies. Some of the people who were unable to make decisions had a legally appointed person [an attorney] to represent them.

The provider told us on their PIR that staff had attended training in the application of the MCA. Members of care staff told us that they had attended such training and were able to demonstrate their knowledge about this. One member of care staff described the strategies they used when a person, who was living with dementia, was declining to take their medicines as prescribed. They said, "I would leave it [the task] a bit and try a bit later and tell them the reason why they need to take it. I give them time." They told us that this strategy worked. Another member of care staff told us about supporting people and this was done in their best interests. They said, "If the person is unable to make a decision for them self, we make the decisions in their best interest. It's also about getting to know them [people] and ask them about what they like." Members of care staff showed us that they carried with them an 'aide-memoire' to remind them of the five key principles set down in the MCA. One member of care staff said that this was, "Very helpful. It is to remind us that we don't assume that people can't make decisions for themselves. It helps us to remember to do things in people's best interest, if they can't [make such decisions.]"

Staff were trained to do their job. Members of care staff told us that they had attended induction training which included 'shadowing' a more experienced member of care staff. One member of care staff said, "I watched at first and read the person's care plan." They added that they were observed when at work, as part of their induction and probationary period. Records showed that staff were 'signed off' to work when they had been assessed fit and safe to do so.

People and relatives told us that the staff were skilled and trained to do their job. One person said, "They know what they are doing." One relative told us that most, but not all, care staff members had an understanding of their family member's dementia care needs. We brought this matter to the registered manager's attention.

Information in the PIR demonstrated that staff attended a range of training. This included, for example, training in health and safety, moving and handling and valuing people's dignity. Members of care staff told us that they had attended such training. In addition to this list, staff were provided with other training opportunities. One member of care staff told us that they had attended training in looking after people living with dementia. They said, "[The training gave me further understanding as no two people are the same. Everyone is different and the training gave me much more insight in to dementia. I now know to be patient with people who are non-verbal and how dementia can affect people's appetite." They also told us that they had attended training in palliative care and end-of-life care and now understood the differences between the two. They told us that they had learnt about, "The emotional side and what to expect if I am ever in that situation."

Staff were also supported to do their job. This was by means of 1:1 supervision and during 'spot checks' when their standard and quality of their work was observed. One member of care staff said, "I had my one-to-one not so long ago. Just to see how I was getting on." Another member of care staff told us that their one-to-one supervisions enabled them to discuss work related matters with their supervisor. Members of care staff told us that these support systems had enabled them to receive positive feedback and support. This in turn had enabled them to enjoy their job in looking after people. One member of care staff said, "I love my job." People told us that staff were kind and this can be seen as a measure of how staff are supported.

We checked to see how people's nutritional needs were met. Most people told us that they were independent with food preparation but added that care staff members always asked how they were managing and if they wanted anything else. One person, who was independent with their food preparation said, "They [care staff] always ask me if I want a cup of tea before they go." Another person told us, "They [care staff] always ask me if I want a cup of tea or something to eat before they leave."

One member of care staff told us how they monitored people's hydration needs. They gave an example of this and said, "I always make sure people have enough juice or water to drink. One person was not drinking enough, so they had a chart. We helped them take about 1.5 litres each day." Another member of care staff told us how they offered people choice of what they wanted to eat and drink. This was in the way the person was able to understand, such as a visual presentation of the choices of soup. One relative told us that their family member was at risk of being undernourished. This was because they preferred to eat high calorie foods above any other healthier types of food. They said, however, that members of care staff encouraged their family member to eat more healthily. This was by leaving out prepared meals for their family member to take, if they chose to do so. They added that their family member was seen by a GP who was satisfied with their nutritional health.

We found that people's individual health needs were being met. One relative said, "They [care staff] have done an excellent job in looking after my [family member's] physical needs." The majority of people who we spoke with said that they were independent with making and attending health care appointments. However, when this was not the case, members of care staff helped people with this. One member of care staff said, "I have taken people to the GP and dentist." The registered manager told us that they worked closely with other health care professionals, who included occupational and speech and language therapists, specialist nurses and dieticians. Electronically held records confirmed this was the case. The

nature of the work also maintained people's sense of well-being with the reduction of social isolation. One relative said, "They [care staff] always stop and have a little chat if they have the time [before they leave]."

Good

Is the service caring?

Our findings

We found that people were satisfied with how they were being looked after. One person said, "I have a carer every morning. They are very good and so friendly. It makes such a difference. They are very kind and will do a job if I ask them." One member of care staff said, "I ask them [people] if there is anything else that they would like me to do. Or sometimes I just stay and have a chat." Another person said, "If they [staff] get caught up in traffic they do ring me." They told us that this had reassured them. One member of care staff told us, "Travelling time has been factored in but if there are delays we ring the customer [person] to say that we are running a bit late."

Members of care staff were aware of people's rights to privacy. One member of care staff said, "Personal care is carried out in private." They described how they provided people with their personal care in the privacy of their bedroom or bathroom. People's level of independence was also respected. This was maintained with eating and drinking and taking their prescribed medicines. One member of care staff said, I don't want them [people] to feel they are not capable of doing anything for themselves."

There was staff awareness in relation to respecting people's independence to remain living at home. One member of care staff said, "I enjoy my job as I like to help people stay in their own homes. And provide the care that they can't do for themselves." In one of the provider's surveys a relative had responded with positive comments. They wrote about how the care had enabled their family member to remain living at home. One relative told us that they had been the main carer for their family member, which left them feeling "very tired." However, the situation had improved as a result of the care provided by the agency. They said, "The [care] staff look after my husband which I can't do." In one person's care records we saw that people's relatives were enabled to provide their family members with care. One of the aims of this is to promote the main carer's feelings of usefulness in order or them to maintain their important role in keeping their family member at home.

People told us that their choices of how they wanted to be looked after were respected. This included choices of what to eat and when to have a bath or shower. One person said that they were satisfied with how their care plan was arranged and that they had been fully involved with this. This included the taking into account the person's choices. In their daily records we saw that people's choices were respected. For example, this included choice of what to eat and when they wanted help to get ready for bed.

People and their relatives told us that, when they had the "regular" care staff they appreciated such continuity because this enabled the forging of quality, therapeutic relationships. One person said, "I don't get the same carers all the time. Which is a bit unfortunate." One relative said, "To have regular staff, that would be nice as you can build up a relationship." One member of care staff said, "I am starting to look after the same people. The consistency helps to build a rapport with each other. Plus the fact you get to know what people like and how they like to have things done." The registered manager told us that people had "regular" staff as much as possible. One member of care staff said, "They [management team] usually try to put us in with people who are used to us. Especially people [living] with dementia."

The registered manager advised us that no advocacy services were in use. However, they were aware of the local availability of these, should there be a need. This included, for instance, independent mental health advocacy services. The provider's MCA policy detailed information in relation to this. Advocacy services are organisations that have people working for them and who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

We checked and found that people's individual needs were being met. One person said, "They [care staff] shower me and wash my hair. They check if I am okay with my food and drink." Another person said, "I get a visit three times week. Monday, Wednesday and Friday. To help me to have a shower or bath." The care that people received not only met their health needs but also their social needs. One member of care staff said that, as part of a planned care, they took a person out shopping. Members of care staff said that they stayed the duration of the call visit. People confirmed this to be the case. One person said that the staff "definitely" stayed the duration of the visit.

The local authority contracts monitoring officer told us that people's care records were in good order and reflected people's individual needs. One person told us that members of care staff "looked at the file" before they started delivering their care. One member of care staff said, "The care plans are very good. They show how people like things to be done and in what order. Their likes and preferences."

The care plans showed that people's needs had been assessed before and after their care had started. This was so that the planned care met the people's individual assessed needs. One relative told us that they had been involved in the assessment process as they were legally able to do so. The team leader described the assessment process, which included receiving information, about the person's assessed needs, from the local placing authority. They told us that this would be considered and compared the demands of the business and staffing numbers. The team leader said that, after they had received the local authority assessment, they arranged a home visit to carry out their own assessment. This included assessments of people's risks; environmental risks and the care, and times of this, that people needed and wanted. The assessment enabled people to provide information about their likes, dislikes and hobbies and interests. Information of which was held in people's care records.

Reviews of people's care was carried out to ensure that this remained relevant in meeting the person's needs. One relative told us that they had attended a review meeting, on behalf of their family member. Changes had been implemented to increase the care to meet their family member's dementia care needs. One person told us that the review of their planned care had resulted in a change in one of their prescribed medicines.

Members of the care and management staff advised us that the majority of people using the agency were of the same white ethnicity. However, the team leader was aware of the cultural needs of other religions, for instance, Islam. This included respecting people's gender preferences when being looked after by male or female staff care staff. They said, "The female person's preference is no male carers because of their religion."

We found that people were aware of the provider's complaints procedure and who to speak with if they needed to raise a concern or complaint. Most of the people told us that they were satisfied with how they were being looked after. One person said, "I have no complaints but I have a number and I know who [registered manager] is." However, one relative said that they had raised a concern with the team leader and

was satisfied with the action taken. The provider told us in their PIR that in the previous 12 months they had received, and resolved to the person's satisfaction, two complaints. However, there was no emerging trend that required any improvement action to be taken.

Good

Is the service well-led?

Our findings

We checked to find out how the agency was being managed. People told us that they were aware of who to contact at the agency office which helped them feel assured. One person said, "[Name of registered manager] has been to see me and has been brilliant in helping me. When I rang [registered manager] they were here straight away. I couldn't ask for anything more." Members of care staff also had positive comments to make about the management style and support of the registered manager. One member of care staff said, "If we have a problem [registered manager] will be there for us. It's nice to know that there is someone there for us." The local authority contracts and monitoring officer told us that they had no current concerns about how the agency was being managed.

The registered manager told us in their PIR how they ensured that they were kept up-to-date. They wrote in the PIR, "To ensure that the service [agency] is up to date I [the registered manager] am a member of a local Registered Manager forum and attend CQC compliance training wherever possible. I attend local training sessions provided by the Local Authority and National Conferences whenever possible. All learning and changes in best practice are shared with my team." The registered manager was supported by a team of management staff and care staff.

Comparing information that we hold with the provider's information we found during the inspection there was no requirement for the provider to submit notifications to us. This told us that the provider was meeting the requirements of the associated regulation.

The management of the agency operated a learning culture. The registered manager said, "You can always improve the service [agency]. No one is perfect and I am quite open to the QA [quality assurance] process." Both the registered manager and team leader told us about the improvements in the management of the agency. They attributed this to a slowing down of the turnover of staff; improved information technology to manage information and staff supervisions and training, and improved training opportunities for both management and care staff. One member of care staff told us that they were provided with the opportunity to develop their career. They said that this was due to the support from the registered manager. The PIR read, "Staff were provided to develop their careers by attending training. The PIR read, "To further develop our staff to support customers with specific disabilities we have arranged for training in specialist areas including Diabetes, Stroke Awareness, Parkinson's and MS [multiple sclerosis], this is starting in October 2016."

Information held in the PIR told us about the quality assurance systems in place. These included, for example audits in relation to people's medicines. The PIR read, "Our medication audit checks were also reviewed to ensure that monitoring is clear, and where actions are required these are fully recorded and reviewed." Other information detailed in the PIR demonstrated that the provider aimed to continually improve the safety and quality of people's care. This included, for example, improved communication between members of care staff and, "to enable this to happen we have introduced daily recording books."

Another example of an area of improved quality and safety was to ensure that staff were providing people

with safe care which met their individual assessed needs. One method used was by unannounced 'spot checks' during which members of care staff's work performance was observed. Members of care staff described the areas of their work that was observed during such 'spot checks.' These included wearing appropriate identification; carrying out correct infection control procedures; respecting and valuing people's rights to privacy, dignity, independence and choice. Furthermore, the 'spot checks' provided the observer to provide feedback to the observed member of care staff. All of the care staff whom we spoke with said that their feedback was positive; there was no remedial action needed to improve the standard of their work.

During 2016 the provider had carried out surveys asking people for their views about the quality of their care. The results of these formed part of the quality assurance and auditing of the agency. Feedback from the survey's respondents was positive. The audit also reviewed other areas and an action plan was drawn up. This showed areas for improvement, which included, for instance, improved communication with people and reminding staff of the appropriate time to make telephone calls. The registered manager advised us that the action plan was now completed. Minutes of staff meetings demonstrated how this action was taken in reminding staff about the standards expected of them.

The staff meetings also enabled staff to make suggestions and comments and for information sharing purposes. The minutes of these showed that staff had been listened to when concerns had been raised about the lack of travelling time between care visits. Members of care staff told us that they had the time to travel between visits. One member of care staff also said that during the meetings they had "learnt a lot" from each other about people's conditions and their care that they needed. Another member of care staff saw the staff meetings as a support system as the nature of their work was that of 'lone working.'

The management of the agency operated an open culture to keep people safe by means of a whistle blowing policy. Members of care staff were aware of this policy and the purpose of it. One member of care staff said, "If I have to do it, it will be to protect the person and myself." Another member of care staff elaborated on this and told us that whistle blowing protected their identity in the event of raising sensitive concerns. None of the staff had reservations in reporting concerns to the management team.