Cleeve Hill Health Care Limited

Gloucestershire Link Homecare

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This was an announced inspection which included a visit to the offices of Gloucestershire Link Homecare on the 25 March 2015. We also carried out visits to people in their own homes on 25 and 27 March 2015. This service moved into this office in August 2014 and this was the first inspection of the service at this location.

Gloucestershire Link Homecare provides personal care to people living in their own homes in areas around Gloucester, Stroud and the Forest of Dean. At the time of our inspection personal care was being provided to over 160 people.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was supported by senior supervisors.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (At the time of our visit the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were in force. These were superseded on 1 April 2014). The provider had made decisions in people's best interests but had not evidenced their assessment of the person's capacity to make particular decisions about their care. The provider had not ensured that care and support was provided with the consent of the relevant person. You can see what action we told the provider to take at the back of the full version of the report.

The registered manager had identified areas for improvement within the service as a result of complaints, safeguarding alerts and accidents. These areas for development included making sure staff were equipped with the skills and knowledge to perform their roles and were competent carrying out their roles. People's care records were being reviewed and replaced with new records. Medicines errors had resulted in staff receiving additional training and replacing some medicines administration records.

People told us they received care which reflected their individual preferences and routines. They said, "All the staff are very nice and very helpful. I look forward to them coming here" and "I'm quite happy with the way I'm treated and I would recommend the service". Staff told us they were supported to carry out their roles through a training programme, individual and team meetings and an accessible manager. Staff said they "loved" their work and provided "good" care.

People said they felt safe. Staff knew how to keep people safe and to report concerns to senior staff. Health professionals said the service worked with them to keep people safe and well after discharge from hospital.

People gave us mixed feedback about how their concerns or complaints were dealt with. Whilst some people were happy with the response and action taken, others felt they were not responded to quickly enough or the appropriate action taken. The registered manager was working to resolve people's experience of making complaints by meeting with them face to face to discuss their concerns no matter how small.

People had different experiences about how their visits were arranged and staff allocated to them. They all wished to have a consistent staff team who understood their needs and how they liked their care to be provided. People who always saw the same staff team and whose visits were stable were positive and spoke highly of staff. People who had different staff and had visit times which changed praised staff but recognised their experience of care could be improved. The registered manager was aware of this and said, "We aim to be the best we can."

Summary of findings

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 were protected against the risks of abuse or injury. Staff raised concerns and the appropriate action was taken to keep people safe.

People liked to have the same staff supporting them. The provider tried to allocate staff to provide consistency and continuity.

People's medicines were administered safely and staff protected people against the risks of infection.

Is the service effective?

Requires Improvement

The service was not always effective. Assessments had not been completed for people who, at times, were unable to make decisions about their care and support. Appropriate records were not being kept for decisions made in people's best interests.

People were supported by staff who had the skills, knowledge and competency to meet their needs.

People were supported to stay well. Their food and fluid intake was monitored and prompt action was taken to refer to social and health care professionals when needed.

Is the service caring?

Good

The service was caring. People were supported by professional staff who treated them kindly and with compassion. People's privacy and dignity was respected and their independence promoted.

People's views were considered in the planning of their care. They had information about their care and support.

Is the service responsive?

Good

The service was responsive. People received care which considered their personal preferences, routines, likes and dislikes. Changes in their needs were responded to flexibly and in a timely fashion.

People knew how to raise concerns and were mostly satisfied with the response to any issues raised. Action was taken to improve the experience of people as a result of complaints investigations.

Is the service well-led?

Good

The service was well-led. People were asked for their views and experiences of their care. Their feedback was used to develop the service.

The registered manager had strategies to drive improvements. Quality assurance systems were used to monitor the service provided to people.

Gloucestershire Link Homecare

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 25 and 27 March 2015 and was announced. The provider was given 48 hours notice because the location provides a domiciliary care service and we needed to be sure they would be available.

This inspection was carried out by three inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert's area of expertise was caring for older people. Prior to the inspection we looked at information we had about the service including notifications and feedback from the local authority commissioning team. Services tell us about important events relating to the service they provide using a notification. 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 service, what the service does well and improvements they plan to make. Prior to the inspection we received feedback from Healthwatch and the local authority commissioning team.

As part of this inspection we visited seven people in their homes. We spoke with them and the relatives of three people as well as eight staff. We had telephone discussions with nine people who use the service and two relatives. We talked with the registered manager, senior management, and two staff working in the office. We received feedback from 11 people using the service in response to questionnaires we sent out. After the inspection we had feedback from three social and health care professionals. We reviewed the care records for ten people using the service, five staff files, quality assurance audits and policies and procedures.

Good

Is the service safe?

Our findings

People said they felt safe with staff in their home and had no concerns about the safety of their possessions. In response to questionnaires we sent out all people said they felt safe receiving care. They told us staff kept them safe, making sure their homes were secure before they left. Key safes were used when needed so staff could enter people's homes when they were unable to answer the door. People were provided with life lines which alerted named people or the service when they had an emergency. Staff checked to make sure people were wearing these before they left people. People commented, "I feel comfortable with different staff visiting, it's not a problem" and "Oh, yes, I feel quite safe".

Any signs of potential abuse to people would be picked up by staff and reported to the office. They knew they had to record any concerns such as bruising or allegations made by people. Staff had completed safeguarding training and had been given information about local procedures. People had also been given information about how to raise concerns and local organisations they could contact. Safeguarding alerts had been made when needed and the registered manager had notified the Care Quality Commission and involved other authorities such as the police. A full record of all safeguarding alerts had been kept with the outcome of any action taken. The registered manager said she reflected on these, "Is there a theme emerging and what can we do better". The registered manager recorded any issues no matter how minor as safeguarding concerns so that action could be taken as early as possible to keep people safe and prevent abuse or harm.

When people had an accident or incident a record was kept providing an analysis of what had happened and any action which had been taken. One accident had been recorded where a person was found on the floor when staff arrived for a visit. They took the appropriate action calling emergency services and informing the office. The office liaised with social care professionals to make sure they were aware of the person's possible changing needs. Another person had been scalded due to water being too hot. As a result all staff had received additional training about how to test the temperature of water. We heard staff checking the temperature of water was satisfactory with a person before delivering personal care.

Risks to people were assessed and strategies put in place to keep them safe from possible harm. For instance where people were at risk of falls guidance was provided for staff about the equipment to be used such as bed rails, hoists or walking frames. Staff observed and monitored people using this equipment checking with them whether they needed additional support. Risk assessments highlighted what people could do for themselves and what they needed help with. Staff said they monitored people's changing needs and contacted the office if they had any concerns. Health care professionals said referrals were made to them when needed.

People's homes were assessed to make sure any hazards to staff were identified and action taken to reduce these wherever possible. Equipment was checked at each review to make sure it had been serviced. During observations of staff as part of the provider's quality assurance process any concerns about equipment or lack of appropriate equipment were highlighted to the registered manager. For example, one person had bed rails but did not have bumpers to protect them from potential injury.

Plans were in place to keep people safe in an emergency. An out of hours service was available for people and staff to call if needed. A new electronic logging in system for staff at the start and end of their visit meant the office could monitor call times but would also eventually be alerted to missed calls. Staff said cover was arranged in an emergency. People understood staff may be held up if people were unwell or emergency services had been called. They said they would be called by the office if staff were going to be very late.

The provider information return (PIR) stated 29 out of 53 staff had left the service. The registered manager said additional staff had been recruited and there were sufficient staff employed to meet people's needs. Staff were allocated to people according to their assessed need. For example where a person needed support with moving and handling they would have two staff. The registered manager described how in some circumstances to protect people and staff, two staff would work together instead of lone working.

People said they liked to have a consistent team of staff supporting them. For some people this was achieved. Other people had different staff and where this was the case people commented they often did not know who would be coming to them for the next visit. A person

Good

Is the service safe?

explained this put extra pressure on staff because they needed to read their care plans or be directed by them about their care and "this all takes time when they are on a strict timetable." One person said they had a rota each week of which staff would be visiting them but not everyone was given a rota unless they requested one. Another person told us, "Continuity has improved; when we started using them [Gloucestershire Link] we never got the same carer twice, but it's much better now".

People understood the challenges of scheduling visits to them. No one reported missed visits and said they would be informed of any delays. The registered manager had allocated staff teams to work in neighbourhoods thereby reducing travelling time between visit and improving consistency. Where visits were close together staff said travel time was not built into the rota but where longer journeys were involved travel time was agreed.

New staff were thoroughly checked before starting work. This involved obtaining a full employment history, verifying their character and fitness to do the work and confirming their identity. A disclosure and barring service check (DBS) had been completed. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with vulnerable people. Police checks and visa requirements were in place for new staff applying from overseas.

People who needed help with their medicines were supported by staff who had completed medicines training. Staff had been assessed as competent to administer and manage medicines. This involved observations of them administering medicines and maintaining medicines records. People had given their consent for staff to administer their medicines. They were requested to supply their medicines in blister packs so they could be given safely. People's care plans and risk assessments stated the support and help they needed to administer their medicines. For some people this was prompting (reminding), assisting or giving medicines to them. The PIR stated there had been five medicines errors which had been investigated and action taken to prevent them happening again. This included staff completing refresher training.

People were protected against the risk of acquiring infections. Staff had completed infection control training. They were given personal protective equipment to wear such as aprons and gloves. Staff washed their hands upon arrival and in between tasks and on leaving. The provider had appointed an infection control lead and had an up to date infection control policy and procedure. An annual statement would be produced in line with the Department of Health's code of practice on the prevention and control of infections.

Requires Improvement

Is the service effective?

Our findings

People had been asked to give their consent for the delivery of their care and support. Records had been signed by them confirming this. Records for three people stated they had either short term memory loss, cognitive impairment or dementia. Their records had been signed on their behalf by relatives which should only happen if they had been registered with the Office of the Public Guardian as a lasting power of attorney (LPA). The provider information return (PIR) had indicated one person had a LPA. A LPA is a legal agreement which allows a person to give authority to someone to make decisions on their behalf. The registered manager said she did not check evidence to confirm this LPA was legally in place for people. There were no assessments to indicate why any decisions had been made in people's best interests in line with the requirements of the Mental Capacity Act (MCA) 2005. The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. People unable to make particular decisions about their care and support were not being helped to participate in the decision making process as far as they were able.

We found that the registered person had not acted in accordance with the Mental Capacity Act 2005. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, where able, were asked for their permission to carry out personal care and were involved in making decisions about how this was delivered. Staff had completed MCA training but in light of our findings additional training was to be provided. Observations of staff delivering care provided evidence of how staff involved people in making decisions about the service they received. Staff were aware of the need to check out with people living with dementia the help and support they needed each day or throughout the visit, due to their fluctuating ability to make decisions.

People told us, "The care staff are excellent, and all seem very well trained" and "The care staff are very good and they know what they're doing". We had a mixed response from people who responded to our questionnaires with 18% of respondents saying staff did not have the skills or knowledge to give care. Staff said they had received training to do the job and felt competent to perform their role and confirmed they had been registered for the diploma in health and social care. The PIR and training records confirmed staff had access to a range of training considered to be mandatory by the provider such as food hygiene, moving and handling and infection control. They also completed training relevant to people's needs such as dementia awareness, end of life care, diabetes and nebuliser training.

People said staff were matched with them and when they felt uncomfortable with a member of staff they were replaced. People were aware of the high staff turnover but most said new staff shadowed existing staff until they got to know them. The registered manager said new staff did not work alone until they had been assessed as competent to carry out their duties through observation of their practice. A new member of staff told us they had received training to do the job and felt competent to perform their role. New staff completed an induction programme and observations of their practice were carried out to confirm their understanding of the training they had completed.

The registered manager said they kept up to date with current and best practice through links with the local authority and local training networks. As a dementia lead they also had access to county initiatives and support from other providers. They had information about the new care certificate and had regular updates from Skills for Care.

People liked to have the same staff supporting them who understood their needs. A person told us, "You get used to a few staff, it's nice to have continuity". One member of staff commented, "The continuity is pretty good, so I really get to know the people I look after". Staff said they were well supported by the registered manager and senior supervisors who had individual meetings with them. The registered manager said they scheduled meetings every three months to discuss the learning and developmental needs of staff and also their performance. Annual appraisals would be arranged to give staff the opportunity to reflect on their role and training needs. A member of staff said they felt happy to speak to their line manager if they needed any extra support.

Where people needed help or support to manage their nutritional or fluid intake this was clearly identified in their care records. People were offered choices about their food

Requires Improvement

Is the service effective?

and drinks. Staff made sure food and drinks were prepared how the person liked to have them. A person said, "They make eggs or beans on toast, whatever I want" and another person told us "They get the breakfast, no problem at all". During a visit, a person was given a lunch which they did not particularly enjoy. Staff offered alternatives including a light snack instead. Food and fluid charts were completed for those people whose diet was being monitored. Care records highlighted where people were living with diabetes or if they had allergies and the impact this had for staff on the delivery of care.

When people's needs changed staff were prompted to record these and contact the office so that social and health care professionals could be contacted if needed. Health professionals confirmed staff worked effectively with them to provide care and raise concerns about people's health or well-being. Details were kept of any referrals or contact with social or health care professionals. Where changes to people's care such as new equipment resulted, the care records in their home were updated with this information.

Good

Is the service caring?

Our findings

People told us, “The boys look after me well” and “Staff are polite and professional”. A person said, “All the staff are very nice and very helpful. I look forward to them coming here”. They told us staff always arrived when they were expected and that staff were gentle and kind towards them. They commented, “I’m quite happy with the way I’m treated and I would recommend the service”. Staff knew people and their relatives well. There was plenty of casual conversation taking place with shared humour and a light hearted approach by staff. Responses to our questionnaires revealed all respondents were treated with dignity and respect and carers were caring and kind. Compliments received by the provider included, the staff were so “kind, friendly, patient and caring” and “they were professional, kind and showed compassion”.

People’s cultural and spiritual needs were identified in their care records in case this impacted on how their care was provided. If people preferred to have their personal care delivered by male or female staff this was recorded. One person told us, “I don’t have any preferences but seem to have male staff which works well.” Where people had sensory needs any equipment they used or adaptations in their home were recorded. Staff checked to make sure people were wearing their glasses or hearing aids.

People had expressed concerns when communicating with staff whose first language was not English. They told us, “The overseas staff do struggle with English pronunciation sometimes” and “I’m not sure how some of the elderly confused people might cope with the language differences”. Social and health care professionals also commented about difficulties for people living with dementia understanding staff who did not speak English fluently. The registered manager had recognised this and in addition to English language lessons held by the provider, staff were registered for English lessons with a local training provider. For other people the communication barrier was not a problem. A person told us, “Sometimes I can’t make out what they’re saying, but we sort it out” and a relative commented, “They ask her, how do you say this, and she loves helping them!”

People’s personal histories and preferences were identified in their care records. Staff had a good understanding of people’s backgrounds and how they wished to be supported. A member of staff showed us a person’s care plan and was knowledgeable about the needs of the person. Over 40% of people who responded to our questionnaires, mentioned they were not always introduced to staff. Staff confirmed where-ever possible new staff shadowed existing staff providing the opportunity for them to be introduced to people.

People were supported with their personal care and although staff had tasks to complete they took time to check on people’s well-being and to focus on them as individuals. Where they had concerns they called the office who liaised with relatives and other professionals. A person told us, “They always ask if there is anything else they can do before they leave, which is nice.”

People had a mixed experience of how actively they were involved in the planning of their visits. Four people told us they did not always know which staff were coming to them or when. They said they did not always receive a rota and their visits times changed. One person had a variation of over an hour in their visit times. The registered manager explained people were told visits could change between 30 minutes either way. A person confirmed this, “They let me know if they’ll be over half an hour late.” One person’s care was delayed whilst waiting for a second member of staff to arrive. They apologised for their lateness. Two people, however, told us how their visits had been re-arranged to fit in with personal appointments.

People were supported to be independent in aspects of their care. Their care records clearly stated what they could do for themselves and what they needed help with. For example, staff were prompted to “respect [name]’s wishes to be independent”. One person told us how they had been able to cancel a lunch time visit because they were now able to manage this independently.

People said their care had been reviewed with them and they were able to make decisions about the delivery of their care. They knew how to contact the registered manager and senior staff at the office. Their care records and information about the service provided were accessible in their home. Relatives said they were kept informed.

Personal information about people was kept securely in the office. When staff passed on information to the office this was done confidentially. Paper records were

Good

Is the service caring?

transferred between the office and people's homes by senior staff only. All staff had company mobile phones promoting confidentiality of text messages and telephone calls.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to receiving a service from Gloucestershire Link Homecare to assess whether the service could meet their needs. The correct level of staff was ascertained for instance if people needed two staff to be allocated to help with their moving and handling. People and their relatives were involved in the assessment of their needs and their wishes for how care should be provided. A person told us, "They write in my record, and the care plan is in the book". People's individual preferences, their routines and likes or dislikes were considered when developing their care plans.

New people using the service had an interim care plan put in place. A person confirmed a senior staff member had visited them to provide a full care plan and risk assessment to replace the temporary care records. Another person said their care had been reviewed with them and changes had been made to their care plan as a result. The registered manager stated reviews for people had fallen behind and we found records in the office did not always reflect the care records in people's homes. They had a schedule to work through and were gradually replacing all care records. Where staff identified changes in people's needs the records in their homes were updated. Staff said these were the versions they worked with. The office was informed of any changes which could prompt a reassessment of needs or a review of care.

People's care records highlighted the care and support they needed to manage their individual conditions and to stay well and independent. For people living with diabetes this included guidance for staff about how to monitor their diet and when to seek specialist advice. Where people needed help with moving and handling staff were provided with step by step instructions and a list of any equipment or adaptations which were in use. If people had concerns about their skin integrity, staff worked with district nurses to maintain the condition of their skin. Staff applied creams if needed and supported people to change position in their bed or chairs as appropriate. Health professionals confirmed staff contacted them when needed.

People provided mixed feedback about whether they received a service when they wanted it and at times to suit them. The registered manager said when new people were assessed their needs could impact on the current rota for some staff. This was evident when for instance people living with diabetes needed their medicines at a particular time. She said they had to be flexible to people's immediate needs in the short term on a risk basis. They tried to arrange visits around these so occasionally times for other people would alter until a more permanent solution could be found. A relative had sent a compliment to the service, thanking staff for their "faultless professionalism. They brought such warmth to their tasks and responded with great sensitivity to the changing needs as they varied from day to day." Health professionals said the service worked flexibly with them to keep people safe when they were discharged from hospital.

We had a mixed response about people's experience of making a complaint. 38% of people who responded to our questionnaires said staff did not respond well to their complaints. People told us they knew how to make a complaint and would talk to staff or the registered manager. They said they had a copy of the complaints procedure in their personal file. People said, "I've never had any reason to complain" and "I'd phone to report a complaint. But I've no complaints". Another person said, "I make complaints on the phone, but never get an honest answer."

The service had received over 20 complaints since the new office had opened. The registered manager said she recorded every issue raised and evidenced how it had been responded to and any action which had been taken. She said by dealing with complaints in this way escalation of the concern was prevented and any emerging trends were identified. She had recognized a common theme amongst complaints being received which focussed on staff being able to put their training into practice. She had found ways of resolving this such as mentoring staff and sourcing additional training. The registered manager realised people had different experiences of making complaints. She preferred to speak with people face to face and use complaints as a way of looking at how and what they "could do better". The Care Quality Commission had received one complaint and the registered manager had arranged to meet with the relative to discuss their concerns.

Good

Is the service well-led?

Our findings

People commented, “We’ve had very good service, and you couldn’t get anyone better”, “Very happy with the service, couldn’t find any flaws in care” and “They have all been excellent. We are very, very happy with them. They go above and beyond”. In response to our questionnaires 64% of people said they had been asked for feedback about the service they received. We had mixed feedback from people we visited. 50% said they had completed surveys or had given feedback as part of their review of care or during a visit by senior staff. The other 50% of people did not think they had been asked for their views.

An annual survey had been sent out to people in 2014. The analysis included other services owned by the provider. Common themes had been identified such as times of visits, travelling time between visits and communicating with the office. The next survey would be sent solely to people receiving care from Gloucestershire Link Homecare and their staff. This would give the registered manager an overview of any themes or trends developing for her service. The provider had introduced improvements to the service as a result of the 2014 surveys such as new systems for monitoring staff visits and improved telephone facilities in offices.

People’s care had been checked by the service periodically. Auditors employed by the provider carried out observations of staff carrying out their duties. This also gave them the opportunity to obtain feedback from people about their experience and to carry out health and safety checks. Any actions identified as part of this process were discussed with staff during their individual meetings with senior supervisors. Telephone surveys had just been introduced and the registered manager was calling people individually to obtain their views about the service they received. This information would be analysed and improvements made to the service where needed.

The registered manager took action in response to complaints, safeguarding and accidents/incidents to improve and develop the service. Improvements included medicines training for staff, new medicines administration records and more observations of staff carrying out their work. The registered manager said, “We aim to be the best we can.” The registered manager had an action plan to make further improvements to the service including the review of all care records, improving the quality of records kept in the office and ensuring staff were used efficiently to improve visits times.

The registered manager said they were supported by senior supervisors, who line managed care staff and a regional manager. They said they felt very supported in their role and had a very good staff team. They stated in the provider information return (PIR) that they reminded staff “this could be your family member” and they aimed to promote a positive culture for staff. Staff told us, “I’m very proud of what I do. I enjoy helping the clients, and really love my job” and “I know I give good care, and from the few other staff I’ve worked alongside, I would say we do as a team too.” The provider told us their vision for 2015 was to have “Happy customers; happy staff.”

Staff were supported to develop and gain new skills. The PIR stated an open door policy was promoted to encourage staff to access the registered manager and senior supervisors. The registered manager said more work needed to be done to ensure staff had regular individual meetings and team meetings. Team meetings focussed on themes such as medicines and safeguarding adults. The registered manager said staff were “treated with respect” and they took disciplinary action or gave additional support when they were required. All staff were given copies of a code of conduct and were guided about how to maintain professional relationships with the people they support.

The registered manager and the provider kept their knowledge and practice up to date through involvement with a local care providers’ association and the local authority. The registered manager also networked with local training and education providers to maintain their professional development and that of the staff. Resources were available to drive improvements to retain staff such as changing the pay structures for staff and improving opportunities to develop professionally and be promoted within the organisation.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not have suitable arrangements in place for establishing, and acting in accordance with, the best interests of the service user. Care and treatment of service users must only be provided with the consent of the relevant person. **Regulation 11 (1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent**