

Foray 577 Limited

Community Care Line Services

Inspection report

Stretton Road
Morton
Alfreton
Derbyshire
DE55 6HD

Tel: 01246861500

Website: www.mortongrangecarelineservices.co.uk

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04 August 2016

10 August 2016

15 August 2016

16 August 2016

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 3, 4, 10, 15 and 16 August 2016. The service was last inspected on 4 August 2014 when they were rated as Requires Improvement overall. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. On 3 and 4 August, phone calls were made to people who used the service and their relatives. On 10 and 15 August, the inspector visited the provider's office, and on 16 August, the inspector visited the provider to give high level feedback on the inspection initial findings.

Community Care Line Services is a domiciliary care agency providing personal care for adults living in their own homes. At the time of our inspection, 242 people were using the service. Community Care Line Services provides personal care for people with a range of needs, including dementia, learning disabilities and physical disabilities.

The service had a registered manager at the time of our inspection visit. 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. The registered manager was not available during our inspection visits.

People were not consistently protected from the risk of avoidable harm. Risks associated with care were not always identified and assessed. People were kept safe from the risk of potential abuse. Staff felt confident to recognise and report concerns.

People were happy with staff who provided their personal care. They were cared for by sufficient numbers of staff who were suitably skilled, experienced and knowledgeable about people's needs. However, people had mixed views about staff arriving at the times they expected them.

The provider took steps to ensure checks were undertaken to ensure that potential staff were suitable to work with people needing care. However, they could not always demonstrate that staff had received a consistent induction. Staff received supervision and had checks on their knowledge and skills. They also received training in a range of skills the provider felt necessary to meet the needs of people at the service.

The systems for managing medicines were safe, and staff worked in cooperation with health and social care professionals to ensure that people received appropriate healthcare and treatment in a timely manner.

Appropriate arrangements were in place to assess whether people were able to consent to their care. The provider met the legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLS).

People felt cared for by staff who treated them with dignity and respect. People were supported to be

involved in their care planning and delivery. The support people received was tailored to meet their individual needs, wishes and aspirations. People, their relatives, and staff felt able to raise concerns or suggestions in relation to the quality of care. The provider had a complaints procedure to ensure that issues with quality of care were addressed.

Systems were in place to monitor the quality of the service provided and ensure people received safe and effective care. These included seeking and responding to feedback from people in relation to the standard of care. However, the systems did not always identify areas where improvements needed to be made. Checks were undertaken on all aspects of care provision and actions were taken to improve people's experience of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not consistently safe.

Risks associated with care were not always identified and assessed. People were not consistently supported at times they wanted and needed. Staff felt confident to recognise and report concerns.

Is the service effective?

Good ●

The service was effective.

The provider met the legal requirements of the Mental Capacity Act 2005 (MCA). The provider took steps to ensure checks were undertaken to ensure that potential staff were suitable to work with people needing care. People were supported to access health services when they needed to.

Is the service caring?

Good ●

The service was caring.

People were supported by staff who understood their needs and preferences, and who provided care in a compassionate way. People's independence was maintained, and care was provided in a way which respected their dignity. Staff understood how to keep information they had about people's care confidential, and knew why and when to share information appropriately.

Is the service responsive?

Requires Improvement ●

The service was not consistently responsive.

People had mixed views about having a consistent staff team to support them. Staff had mixed views about care plans having enough information to be able to understand people's needs. The provider had a responsive system to resolve concerns and complaints.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

The provider had systems to monitor and review all aspects of managing the service, but these did not always identify risks or areas for improvement. The provider's whistleblowing policy supported staff to question practice and raise concerns about care.

Community Care Line Services

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 3, 4, 10, 15 and 16 August 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection visit was carried out by one inspector and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete 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. This was returned to us by the service.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. For example, notifications of serious injuries or allegations of abuse. We spoke with the local authority and health commissioning teams and Healthwatch Derbyshire, who are an independent organisation that represents people using health and social care services. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group. Before the inspection, we sent questionnaires to people, relatives and staff asking questions about the quality of care. We received responses from 22 people, 2 relatives, and 21 staff.

During the inspection we spoke with 17 people who used the service, and 8 relatives. We also received feedback from two health and social care professionals. We spoke with four care staff, two care

coordinators, the service administrator, and the deputy manager. We looked at a range of records related to how the service was managed. These included five people's care records (including their medicine administration records), three staff recruitment and training files, and the provider's quality auditing system.

Is the service safe?

Our findings

People were not consistently kept safe from risks associated with their health conditions and personal care needs. People's care plans did not always include relevant information about risks to their safety and how to protect people from the risk of avoidable harm.

Two people were identified as being at risk from falls. Their risk assessments did not include relevant information about their history of falls, and did not identify any steps staff should take to minimise the risk of further falls (known as control measures). One of the people at risk of falls had daily care records stating staff were assisting them to get out of bed and to move around. There was no risk assessment or guidance in place for staff to do this safely.

Three people's care records identified that they were at risk of developing pressure sores on their skin. There were no assessments in place to identify risks or say what actions staff should take to minimise the risk of skin breakdown. There was no guidance for staff on how to monitor, or what to do if they were concerned about the person's skin.

Another person had a diagnosis of diabetes, and a support plan written in December 2013 identified they had risks associated with their diabetes and nutrition. There was no clear risk assessment, care plan or guidance for staff to enable them to support the person correctly.

The deputy manager and service administrator acknowledged that risk assessments were not in place for the people whose records we looked at. They assured us that this would be done. This meant at the time of our inspection, risks were not clearly identified for all people, and although staff were knowledgeable, they did not have consistent written guidance to minimise avoidable harm to people.

People and their relatives felt staff knew how to manage risks safely. One person said, "I can't walk or stand very well, and have a rotunda. They [staff] keep talking so I know what they are doing and they know when I am ready." A rotunda is equipment designed to enable people to increase their mobility safely. A relative said, "They [staff] are constantly checking for sores." We spoke with staff about risks associated with people's personal care. They were knowledgeable about people's individual risks, and what they should do to ensure people were cared for safely.

There were enough staff to provide the care people needed. However, people had mixed views about staff being on time. For example, one person said staff were not consistently on time, but commented, "It is not a problem." Another person said, "I would like [staff] to attend consistently as agreed. This is not always the case." A relative commented, "It is just we are not sure what time they will be coming." People and relatives also had mixed views on whether or not they received a rota in a timely way to let them know which staff would be supporting them.

Staff said they felt there were enough staff to support people with their personal care needs. Staff also felt there was usually enough time for each visit, but said they would let the provider know if the visit time

needed to be longer. The provider expected staff to call the office if they were running late, so that people could be told about this. Staff told us and records showed that this happened. The provider took steps to ensure people were allocated staff at the times they wanted their personal care provided, but this was not always achieved. We saw that people were not consistently supported at times they wanted and needed this.

People felt staff supported them in ways that kept them safe. One person said, "Without my carers being here to help support me, I just wouldn't be able to have a shower anymore as I wouldn't feel safe on my own." Another person said, "They always make sure I am safe." A relative said, "[Staff] go out of their way to make sure [my family member] feels safe while they are hoisting them."

People were kept safe from the risk of potential abuse. They told us they felt confident to tell staff or phone the office if they were concerned about anything. Staff knew how to identify people at risk of abuse. One staff member said, "Safeguarding is always in the back of my mind." Staff were confident to recognise and report concerns about abuse or suspected abuse. They also knew how to contact the local authority or the Care Quality Commission with concerns if this was needed. The provider had a policy on safeguarding people from the risk of abuse, and staff knew how to follow this. Staff received training in safeguarding people from the risk of avoidable harm and this was recorded in training records we were shown.

People's files contained emergency information and contact details for relatives and other key people in their lives. Staff told us there was an out-of-hours number for them to call in the event that they needed support from a senior colleague. There were plans in place to ensure people would continue to receive care in the event of an emergency. For example, the provider had a business contingency plan in place to ensure people would continue to receive personal care in the event of disruption caused by adverse weather.

Staff told us, and records showed the provider undertook pre-employment checks, which helped to ensure prospective staff were suitable to care for people receiving personal care at home. This included obtaining employment and character references, and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is safe to work with vulnerable people. All staff had a probationary period before being employed permanently. This meant people and their relatives could be reassured staff were of good character and were fit to carry out their work.

People's medicines were managed safely. People felt staff supported them to manage their medicines safely, and confirmed that staff recorded this. One relative said, "My family member has tablets given from the blister packs, with a drink by the carer. I know that once they have taken them, staff fill in the MAR (medicine administration record) to confirm this. I check the records when I visit." People's medicines were administered by staff who had received training in managing medicines safely. Staff understood what level of assistance people needed to ensure they received their medicines as prescribed, and records showed people were assessed in relation to the level of support needed to ensure they had medicines as prescribed. Staff told us and records showed they had received training and had checks to ensure they managed medicines safely. Staff also told us and records showed that they knew what action to take if a person missed their medicine for any reason. This demonstrated medicines were managed safely and in accordance with professional guidance.

Is the service effective?

Our findings

The provider was working in accordance with the Mental Capacity Act 2005. This meant people were at risk of not having their rights upheld with regard to consent to care. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. For people living in their own homes, the authorisation for restrictive care is made to the Court of Protection. No-one using the service was receiving personal care in a way that required a court authorisation.

We checked whether the provider was working within the principles of the MCA, and found that they ensured assessments of people's capacity were carried out when required. Where people had capacity to consent to their personal care, this was documented. One person's care records we looked at did not have assessments of capacity that were specific to a particular decision. The MCA requires assessments of capacity to be done in relation to specific decisions. The provider's forms for documenting capacity assessments and best interest decisions did not guide staff to assess people's capacity about specific decisions. We spoke with deputy manager about this and they assured us action would be taken to improve this area of care.

People and their relatives confirmed that staff sought permission before offering personal care. Staff said they received training in the MCA and demonstrated they understood what the law required them to do if a person lacked the capacity to make a specific decision about their care.

People were supported by staff who were trained and experienced to provide their personal care. One person said, "The carers know what they're doing, helping me get washed and dressed."

All staff had a probationary period before being employed permanently. New staff undertook the Care Certificate as part of their induction. The Care Certificate is a set of nationally agreed care standards linked to values and behaviours that unregulated health and social care workers should adhere to. The provider had an induction for new staff which included training, shadowing experienced colleagues, being introduced to the people they would be caring for, and skills checks. Staff told us they received an induction when they started work and spot checks on their care skills, which they felt gave them the skills to be able to provide personal care for people. However, we found that this was not always being recorded. For example, three staff files had no information about their induction or initial training and assessment. We spoke with the deputy manager about this and they assured us action would be taken to improve this.

Staff undertook training in a range of areas the provider considered essential, including first aid, safeguarding, and caring for people at the end of life. Staff told us and records showed that they received refresher training in care skills. However, not all staff understood the difference between valid consent, and

when a person was complying with requests to provide care without understanding why this was needed. This demonstrated that although staff understood the importance of seeking consent to care, there was a risk their training on the MCA was not always being put into practise effectively. The provider also undertook unannounced checks on staff, and one staff member said, "I have had spot checks – I think they [the provider] should do this more." There were regular staff meetings which enabled staff to discuss information relating to people's care. Staff also had individual meetings with their supervisor to discuss their work performance, training and development. They told us this was an opportunity to get feedback on their performance and raise any concerns or issues. This showed the provider ensured that staff maintained the level of skills they felt staff should have to meet people's needs.

Staff told us and evidence showed that they kept daily records of key events or issues relating to people's care. Information about people's daily personal care was recorded in a folder kept in people's homes. Significant issues or concerns were also communicated to the care coordinators to take action where appropriate. For example, when staff said they were concerned about a person who had been struggling to stand, records showed staff told care co-ordinators who then liaised with the person to request an assessment for additional support. This meant that staff identified what the daily issues were and took action to ensure that people received the care needed or requested.

People who received support to maintain a balanced diet told us they were happy with the assistance staff provided. One person described how they had been struggling one day to eat, and staff stayed with them to ensure they had support to finish their meal. Another person said, "I need to drink a lot of water. They make sure I have enough and always leave me drinks before they go." Staff told us, and records showed that people who needed support to ensure they had sufficient food and drinks got this. Staff recorded food and drink people had or were offered, and where they had concerns, raised this appropriately. This meant people were supported to have sufficient food and drinks.

People told us they were supported to access health services when they needed to. One person said, "Oh yes – they notice if I am not very well." Another person spoke positively about staff who called emergency services because they were unwell, and stayed with them until an ambulance came. A relative said, "We had the paramedics the other day at the carer's insistence. They [staff] are very quick to notice things like water infections." Staff told us, and records supported, that people were supported to access health services in a timely manner when needed. Records also demonstrated how staff recorded any concerns or action needed in relation to people's health. This enabled staff to monitor people's health and ensure they accessed health and social care services when required.

Is the service caring?

Our findings

People were supported by staff who understood their needs and preferences, and who provided care in a dignified and compassionate way. One person said, "My carers never mind helping me; that makes all the difference." Another person said, "They [staff] are very caring."

People's care plans showed people's preferences about how they were supported were documented. For example, one person's care plan contained detailed information about their bathing routine and personal choices, and what they could do for themselves. We saw that where people expressed a preference for particular staff, the provider tried to ensure they were supported by these staff. Where people did not want a particular staff member involved in their care, this choice was also respected. This meant people's personal choices were respected.

People felt their independence was important, and said staff encouraged them to maintain this. One person said, "I can cope on my own here at home with some carers coming in. It's important to me to keep my independence." A relative commented, "It's important to [my family member] that they still try to do as much as they can for themselves, and the carers really encourage this."

People and their relatives said they were involved in planning and reviewing their care and support. Staff told us, and records confirmed that people were supported to express their views and wishes about their daily lives. The provider ensured people had their personal care needs reviewed, and relatives were involved with this where people consented.

People were treated with dignity and respect by staff who provided their personal care. People described staff who always ensured that bathroom doors were closed and curtains drawn when providing personal care to ensure this was done in private. One person said, "My carers never start undressing me without making sure the curtains are shut." Another person said "They never rush me, but take their time. They are very patient with me." Staff spoke about how they supported people with dignity and respect. Several staff commented that they treated people in the way they would like to be treated themselves. This demonstrated dignity and respect for people were central to the staff's values.

People felt staff ensured their personal information was treated in confidence. One person said, "I never hear them talking about anyone else they visit." Staff understood how to keep information they had about people's care confidential, and knew why and when to share information appropriately. Care staff had access to the relevant information they needed to support people on a day to day basis. This showed people's confidentiality was respected.

Is the service responsive?

Our findings

People had mixed views about having a consistent staff team to support them. One person said, "It seems at the minute that I always have someone new. I end up having to explain everything over and over again." Another person said, "There is one regular and the others come as and when." However, most people spoke positively about having the same staff team to provide personal care.

Staff had mixed views about care plans having enough information to be able to understand people's needs. One staff member said, "There's enough information there, and I also look at the [daily] communication logs." Another staff member said they thought a clearer one-page summary would be helpful, particularly when it came to passing essential information on in an emergency. A third staff member said, "Sometimes the little details are not in the plan – everyone is different." They were able to provide detailed information about several people's care preferences, and described how information was passed to care coordinators in the office, but acknowledged this information was not always in care plans. The care plans we looked at did not always have detailed information about what people's needs were, and what their views were about how they were supported. This showed the provider did not always document sufficient information about people's needs in order for a good quality of care to be provided. There was a risk that important information known to staff providing care was not recorded to ensure a consistent approach to meeting care needs in the way people wished.

People told us they had opportunities to provide feedback on the quality of their care. This was done through surveys of people's views, and by speaking with care staff and phoning the provider's office. Staff and the provider confirmed that the office was open seven days a week, with people, relatives and staff able to seek support from senior colleagues when the needed. The provider also sent people and their relatives a newsletter. This contained information on what feedback they had received and what actions they planned to take to improve the service. For example, the newsletter sent in June 2016 showed the results of the most recent survey. Where people had raised concerns about any aspect of the service, the provider had arranged individual reviews. This was to give people and relatives the opportunity to discuss concerns further and to take steps to improve the service. This demonstrated the provider listened to people's views and suggestions to improve the quality of care and took action.

The provider was registered to provide personal care. However, they also gave people opportunities to participate in trips and events. These were run with the provider's other service, which is a care home. People and their relatives were informed about upcoming events via the monthly newsletter.

People felt any issues or complaints would be handled appropriately by the provider. They felt able to raise concerns and knew how to make a complaint. One person said, "They'd listen to me – they always have done in the past." Another person said that they had requested staff changes on two occasions and this had been sorted out to their satisfaction. A relative said, "I'd ring up and speak to one of the managers. I think they would listen to me and want to sort things out." Staff knew how to support people to make a complaint. One staff member said that a person said they did not want them (staff member) doing their care. The staff member said they passed this to the care coordinator, who ensured the person's wishes were

respected. Information about how to make a complaint was given to people, and we saw this was kept with the records of care which people had at home. The provider had a complaints policy and procedure in place, which recorded the nature of the complaint, what action was taken and who had responsibility for this. Information from daily care records and phone calls to the office about issues were audited regularly to enable the provider to see where people were having issues with the quality of their care package. However, the audits we looked at did not always result in action being taken. We spoke with the deputy manager about this, and they agreed they would look at improving this. The provider also looked at complaints on a monthly basis to see whether there were any themes they needed to take action to improve. This meant the provider had a responsive system to resolve concerns and complaints.

Is the service well-led?

Our findings

The provider had systems to monitor and review all aspects of managing the service. This included regular monitoring of the quality of care. However, the record keeping for this was not always accurate. For example, the weekly management meetings looked at medicine errors. We looked at the meeting minutes for June 2016, and the corresponding medicines errors file. Medicine errors discussed in the meetings did not always have a corresponding form, where the original issue was documented. However, we saw that medicines errors were also recorded in people's electronic call logs, and it was this information that was used in the management meetings. We spoke with the deputy manager about this, and they agreed they needed to ensure that where records were kept in different formats, they were accurate.

The audits of people's care records had not identified that some people did not have relevant risk assessments and associated care plans. A recent action plan, created by the provider in June 2016 after concerns about a person's care, stated that there was a system in place to identify people most at risk of developing pressure sores. The provider said they would also ensure staff continued to report concerns so that prompt action could be taken. At the time of our inspection in August 2016, the provider could not demonstrate that risks in relation to skin breakdown had been assessed for people who needed this. This meant systems to audit the quality of care did not always highlight areas where the service needed to improve.

People felt the service was managed well. One person said, "I know [care coordinator] really well. I wouldn't hesitate to approach them with any concerns." Another person spoke about the difference that staff had made to their quality of life, stating, "I think it is very good myself. I couldn't manage without them." Staff spoke positively about their work and the support they received from the manager and from each other. They felt confident to raise concerns or suggest improvements.

Staff understood their roles and responsibilities, and demonstrated they were trained and supported to provide care that was in accordance with the provider's statement of purpose. A statement of purpose is a legally required document that includes a standard set of information about a provider's service, including the provider's aims, objectives and values in providing the service.

The provider appropriately notified the Care Quality Commission of any significant events as they are legally required to do. They had also notified other relevant agencies of incidents and events when required. The provider had taken appropriate and timely action to protect people and had ensured they received necessary care, support, or treatment. They also monitored and reviewed accidents and incidents, which allowed them to identify trends and take appropriate action to minimise the risk of reoccurrence. The service had established effective links with local health and social care organisations and worked in partnership with other professionals to ensure people had the care and support they needed.

The provider carried out checks of care provided, and was looking at ways to improve the quality of care provided. For example, staff involved in managing the service had identified spot checks on care as an area to improve in, and spoke with us about how this would help in improving the quality of the service by

providing them with more frequent evidence about the quality of care. However, this had not identified issues relating to concerns people had raised about staff not arriving when expected.

We saw organisational policies and procedures which set out what was expected of staff when supporting people. Staff had access to these, and were knowledgeable about key policies. We looked at a sample of policies and saw that these were up to date and reflected professional guidance and standards. The provider's whistleblowing policy supported staff to question practice and assured protection for individual members of staff should they need to raise concerns regarding the practice of others. Staff confirmed if they had any concerns they would report them and felt confident the manager would take appropriate action. This demonstrated an open and inclusive culture within the service, and gave staff clear guidance on the standards of care expected of them.