Northamptonshire County Council

CRT

Inspection report

Highfields
Cliftonville
Northampton
NN1 5BD

Tel: 03007770002

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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

CRT is a short term domiciliary care agency, used by people in their own homes in crisis situations. For example, when released from hospital, CRT can support people in the first few weeks of their return home to re-enable them to carry out their own personal care needs independently. Or, if people have longer term care needs, CRT can support people on a short-term basis whilst they find a longer-term care provider.

This inspection took place on 11, 12 September and 4 October 2018 and was unannounced. The provider of this service had recently changed and therefore this was the first comprehensive inspection for this service under the new ownership. At the time of the inspection the service was supporting 42 people with their personal care needs.

This service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People received safe care and staffing arrangements were flexible to meet the demands of the service. People received support with their medicines if they wished and systems were in place to record and report safeguarding concerns.

People's needs were fully considered before they began to use the service to make sure their needs could be met. People's consent was gained before their care was provided. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were treated with dignity and respect and staff were commended for their cheery approach. People were encouraged to be independent and to make their own choices.

People had care plans in place which reflected their needs and these were updated when people's needs changed. Complaint procedures were in place for people to make a complaint, and the registered manager had a good understanding of the requirements of end of life care.

The provider had quality assurance systems in place to review the quality of the service and took action to make improvements where required. People and staff had opportunities to provide their feedback and this was fully considered and acted on.

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 received their care in a safe way. People were supported with their medicines if required and staff were recruited effectively.

Is the service effective?

Good

The service was effective.

People's needs were assessed before they began to use the service and people's consent was sought appropriately to the care they received. Staff were trained and supervised by management and this was regularly reviewed.

Is the service caring?

Good

The service was caring.

Staff were kind and treated people well. People were treated with dignity and respect and staff encouraged people to make their own choices.

Is the service responsive?

Good

The service was responsive.

People had care plans in place which were updated when people's needs changed. Arrangements for managing complaints were embedded into the service.

Is the service well-led?

Good

The service was well led.

The service had a registered manager in post and there were quality assurance systems in place to review and improve the care people received. The registered manager proactively liaised with other healthcare services to improve the consistency of care people received.

CRT

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 was a comprehensive inspection which took place on 11, 12 September and 4 October 2018 was unannounced. We visited the office and made visits to people in their homes on 11 September. We spoke with people on the telephone on 12 September and returned to the office on 4 October to meet with the registered manager.

The inspection team consisted of two 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-by experience for this inspection had experience of social care community support services.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification provides information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people living in the home, and other healthcare agencies that work in close liaison with this service to identify if they had any information which may support our inspection.
Before the inspection we did not request 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.

During our inspection, we spoke with six people who received support with their personal care and two relatives. We also spoke with two members of care staff, one member of the scheduling team, the providers training lead, the deputy manager, the providers representative and the registered manager.

We reviewed three staff files and the care plan documentation for three people. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, training information, staffing rotas, and arrangements for managing complaints.

Good

Is the service safe?

Our findings

People commented that they felt safe using the service, and they understood that staff were there to help promote and encourage their independence in a safe way. People were happy with how staff supported them, and challenged them to try and take on more of their personal care if they were able to. One person said, "I can manage the loo on my own, they [the staff] put the commode near me at night so I can get to it." Staff had a good understanding of how they could keep people safe in their homes and worked with people to ensure they felt safe.

People had risk assessments in place which identified their risks, and how these could be minimised. For example, risk assessments were in place to consider if people could manage their own medicines safely. Staff had an awareness that people's abilities fluctuated and staff were responsive to those changing needs. Risk assessments were reviewed as people's needs changed, and the care people required to keep them safe was flexible to ensure people's needs were met during each visit.

People were encouraged to manage their own medicines if they were able to do so safely, however staff also supported people with their medicines if required. One member of staff said, "We try and encourage people to self-administer their medicines if they can, but if I do it I always check the label and make sure people are having the right medicines at the right time. I check that they swallow them and then sign the chart to record what they've had." We saw that staff used Medication Administration Records (MAR) to show what medicines people had and these were completed correctly.

Staffing requirements were adjusted to meet the demands of the service. Due to the continuous changes to the support people required, and the fluctuating number of people using the service, people did not always have a dedicated team of staff to support their needs. The service did however prioritise people with high risk needs, for example, time critical medicines, or people that had higher dependency needs. One person said, "I never know who's coming but I am ok with that. They're always polite and they say good morning. I've seen a lot of them now, some are regular faces, some you get to know some you don't." One member of staff said, "We try our best to keep the same staff going to the same people but it's just not always possible." We saw that staff rotas were created to help minimise travel time, and where possible staff supported the same person if they were on shift.

The service had appropriate recruitment practices in place. Records confirmed that references were obtained from previous employers before new staff were able to provide care for people and Disclosure and Barring Service checks were also completed. These are checks to make sure that potential employees are suitable to be working in care.

People were protected from the risk of infection. Staff had a good understanding of how they could help to prevent the risk and spread of infection. Staff were expected to wear disposable gloves and aprons when they were supporting people with their personal care to maintain good hygiene standards and people and their relatives confirmed that staff used this during each visit. The service had invested in supporting one member of staff to become an infection and control champion, so staff had a single point of contact to raise

any concerns and help resolve them efficiently.

The service had safeguarding procedures in place. Staff were knowledgeable about safeguarding matters and how to report them. One member of staff said, "If there were any safeguarding concerns I would report them to the team leader, supervisor or manager." Staff were also knowledgeable about the Care Quality Commission and understood their responsibility to report any concerns. Safeguarding investigations were completed in depth and were reviewed to identify if any learning could be identified from any incident. Where necessary, staff performance was reviewed and improvements were made. For example, when there had been a medication error appropriate action was taken to make the required improvements.

The registered manager encouraged an open approach if there had been any accidents or incidents at the service and shared relevant information with staff to identify if there had been any learning or good practice. The registered manager praised staff when they had been working through difficulties and supported staff to share their own learning.

Good

Is the service effective?

Our findings

People's needs were assessed before they used the service. The service regularly supported people that had been in hospital for a period of time, and once they were back home, staff from CRT visited them and completed an assessment of each person's current needs. Information was given to people about the nature of the short-term service and that they would be unable to support people on a long-term basis. People understood that where possible, they would be supported to become as independent as possible whilst they regained their health and personal abilities. One member of staff said, "We go through a thorough assessment and see what help they need. We talk about the equipment we can bring to help support people – it might just be a toilet raiser [a piece of equipment that prevents people from having to bend down too low to use the toilet] that could really help them."

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. Applications to deprive a person of their liberty in their own home must be made to the Court of Protection. The service worked in line with the principles of the MCA, and had carried out capacity assessments appropriately for people that required them.

Staff had the appropriate skills to support people with their personal care needs. One member of staff told us, "I'm proud to wear this t-shirt [uniform]. We're big on training and don't throw anyone in at the deep end. There's lots of shadowing, no time limit to shadowing if that's what we need. We've got good tools and support in place to do a good job." Each new member of staff was required to complete an induction and shadow experienced staff before they could support people with their care. Staff felt the training they received helped to prepare them for the role they were completing.

Staff felt supported in their roles and their performance was regularly reviewed. One member of staff said, "I'm already writing assessments for people, and this is checked by the supervisors. I've only been here a little while and I've already had supervision… I've been given feedback about what I'm doing, it's given me a boost. The other staff are so welcoming and helpful." Staff had regular supervisions and an annual appraisal. Management worked with staff to improve their performance and ensure people received care from competent staff.

People were supported to eat well and in line with their preferences. One person said, "My appetite has gone a bit, they [the staff] encourage me to eat. If I don't eat it all they would soon tell me!" Another person told us, "When I came out of hospital the first night they [the staff] came and cooked me a meal, but now they try to make me do it if I can." Staff worked with people to make their own meals if they were able, or to give them choices if they needed staff support.

Staff had a good understanding when people needed additional support to manage their healthcare needs. For example, staff could request additional support from other healthcare professionals such as an occupational therapist, or nursing team, if required. Staff talked to people about their health and how they were feeling and took appropriate action when required.

Good

Is the service caring?

Our findings

People commented on the cheerfulness of staff, and that they were a positive influence on them and their road to recovery. One person said, "I think they're [the staff] very good." Another person said, "I am quite happy with the care, they're all very kind and gentle and they get the job done." We also saw that the service had received letters of thanks. One card read, "I have nothing but praise for these hard working, friendly, caring girls. I do not know what we would do without such a wonderful service."

People were encouraged to make their own choices about their care and to be as independent as possible. One person said, "They encourage me to do things… and ask me what I want." Staff told us that their main aim was to help support people with their independence, if they were able to, to support people to take on tasks for their personal care but that sometimes people didn't always understand this. One member of staff told us, "Sometimes people think we're lazy if we don't do everything for them, but that's not the point of the service. We need to try and help people to do things for themselves – if they can!"

People and their relatives were involved in making decisions about people's care. We saw that people's care plans showed that people had been involved in making decisions about their care and preferences. One relative told us, "I've been involved from the start and I know what's going on. They explained the limitations of the service and what equipment they could help us with, like a key safe." People's care plans reflected the care that the staff would provide.

People told us they were treated with dignity and respect, and staff had an awareness of cultural differences. One member of staff told us, "We are aware that we are visiting people in their own homes and we're mindful that they should be treated with dignity and respect at all times. We use shoe covers, for example, if people want us to cover our shoes in their homes." People were able to specify specific preferences, for example if they would prefer to have male or female members of staff to support them with their personal care, and this was accommodated.

The provider had a good understanding of advocacy services and how this could be used for significant decisions, or if people required independent support to make decisions about their care. An advocate is a trained professional who supports, enables and empowers people to speak up. At the time of inspection, nobody required the use of an independent advocate.

People's information was stored securely at the office and staff understood the importance of confidentiality and privacy.

Good

Is the service responsive?

Our findings

People had a care plan in their homes that reflected their care needs and this was accessible for staff. Staff wrote clear records about the care they provided to people and they could access the information before they arrived at each person's house so they were prepared for what support may be required as electronic records were also completed by staff. We reviewed the daily records and saw that people received care in accordance with their care plans.

People received care that was personalised to their needs. Care plans provided appropriate guidance for staff about people's care preferences and what they liked and disliked. In addition, staff provided comprehensive updates to the care plans to ensure they were accurate with people's current needs. Staff recognised that people's needs changed on a regular basis, and therefore the care plans were kept up to date to match people's needs.

Staff showed an interest in people's lives and took time to get to know them. We saw that one person had photographs and memorabilia about the war, and staff used this to generate conversations with people and things that mattered to them. Staff told us they had enough time to ensure people got the care they required and this was individual to their needs.

Staff had a good understanding of people's communication needs and made efforts to make this as easy as possible for people. We saw one person's feedback which praised the staff's patience and communication tools as they were deaf. They were grateful for the cheery approach of staff, and the patience they had in supporting the person to communicate in their own time.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. For example, the service had asked people to provide feedback about the service and had used simple questions in an easy read format.

People and their relatives understood how they could complain and there was information available about how they could do this. In each person's care plan, they had access to information about how to make a complaint, and staff were aware that if people wanted to make a complaint they would support them to do so. The provider had a complaints policy in place and all complaints were investigated and reviewed for future learning.

Systems were in place to help support staff provide good end of life care. The provider had recognised the challenges for people on end of life care, and had worked with a local hospice to provide training for staff about the key areas of care. The provider had supported three members of staff across the services to become end of life champions to also help improve knowledge and consistency of care at this time of people's lives. At the time of the inspection nobody was being supported with end of life care.

Good

Is the service well-led?

Our findings

The service had a registered manager in post. 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 provider had quality assurance procedures in place which reviewed the quality of the service. People's daily records were reviewed to ensure people received the care they required and if there were concerns the management team acted on this, for example by discussing issues with staff or reviewing training requirements. We found that one audit was not specific about the improvements required to people's care plans. However, work was already underway to make those improvements. The registered manager confirmed they would ensure actions in the audits would be made clearer.

The registered manager was keen to drive improvement and make the service the best it could be for people. They had identified that improvements were needed to medication procedures and had arranged for a comprehensive review of this. Actions had been identified to make those improvements and at the time of inspection, those changes were underway with good feedback from staff. Auditing systems on medication records also identified where improvements were required and if it was identified that staff required further support, training or guidance, this was arranged.

People were supported to provide feedback about the care they received. Every person using the service was given a survey to complete about the quality of care they received. Feedback was very positive, and the provider had fully analysed and acted on the results. Staff had been praised for their good work, and the provider was committed to providing a high standard of care.

Staff had regular staff meetings and felt valued by the registered manager. We saw that staff were regularly asked during team meetings if there were any suggestions for change or improvement and staff felt their ideas were listened to. This could be, for example, in the way staff provided care and support to people, or about helping the service to work better. The registered manager welcomed feedback and ensured staff were involved in the running of the service.

The service worked positively with outside agencies. This included liaising with other care providers, particularly the local hospitals. The registered manager raised concerns and sought changes where necessary to ensure people received co-ordinated care which helped to improve their lives. For example, the registered manager had identified that people were being discharged from hospital with insufficient information about the medicines they required once they were home. They had worked with the hospitals to change practice in this area, to ensure the CRT could provide safe care for people once they were home.

The registered manager had a good understanding of the statutory requirements of the service, and to submit statutory notifications to the Care Quality Commission (CQC). The registered manager was also aware of the requirement to dominantly display their CQC rating in the office location and on their website.