Peacefulliving Limited

Peacefulliving Oxfordshire

Inspection report

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an announced inspection of Peacefulliving on 15 February 2018.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community [and specialist housing]. It provides a service to older adults in Banbury, Oxfordshire and the surrounding area. At the time of our inspection three people were being supported by the service.

There was 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.

Where risks to people had been identified, risk assessments were in place and action had been taken to manage the risks. However, risk assessments were not always accurate or up to date and did not always provide staff with adequate guidance to manage these risks. Some risk assessments were generic and not personalised.

People told us they benefitted from caring relationships with the staff. There were sufficient staff to meet people's needs and people received their care when they expected. Staffing levels and visit schedules were consistently maintained. The service had safe, robust recruitment processes.

People were safe. Staff understood their responsibilities in relation to safeguarding. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

At the time of our inspection none of the people using the service were supported with medicine. People told us their relatives supported them with medicine.

Staff had a good understanding of the Mental Capacity Act (MCA) and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The registered manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected.

People were treated as individuals by staff committed to respecting people's individual preferences. The service's diversity policy supported this culture. Care plans were person centred and people had been actively involved in developing their support plans.

People told us they were confident they would be listened to and action would be taken if they raised a concern. We saw a complaints policy and procedure was in place. The service had systems to assess the quality of the service provided. Learning was identified and action taken to make improvements which

improved people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

Staff spoke positively about the support they received from the registered manager. Staff supervision and meetings were scheduled as were annual appraisals. Staff told us the registered manager was approachable and there was a good level of communication within the service.

People told us the service was friendly, responsive and well managed. People knew the managers and staff and spoke positively about them. The service sought people's views and opinions and acted upon them.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activity) Regulation 2014. You can see what action we have required the provider to take at the end of this report.

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 always safe.

Risk assessments were not always accurate, up to date and personalised.

There were sufficient staff deployed to meet people's needs.

People told us they felt safe. Staff knew how to identify and raise concerns.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and understood and applied its principles.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respectful and treated people and their relatives with dignity and respect.

People were involved in their care.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and gave clear guidance for staff on how to support people.

People knew how to raise concerns and were confident action would be taken.

People were treated as individuals and their diverse needs respected.

Is the service well-led?

Requires Improvement

The service was not always well- led.

The service had systems in place to monitor the quality of service. However, these systems were not always effective.

The service shared learning and looked for continuous improvement.

There was a whistle blowing policy in place that was available to staff around the service. Staff knew how to raise concerns.

Peacefulliving Oxfordshire

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 15 February 2018 and was announced. We told the provider two days before our visit that we would be coming. We did this because the registered manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that someone would be in. The inspection was carried out by two inspectors.

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. We looked at information we held about the service. This included previous inspection reports and notifications we had received. Notifications are certain events that providers are required by law to tell us about. In addition we contacted the local authority commissioners of services to obtain their views on the service.

We spoke with two people, one relative, three care staff and the registered manager. During the inspection we looked at three people's care plans, four staff files and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Risks to people were managed and reviewed. However, risk assessments were not always accurate and up to date. For example, an assessment conducted by Oxford Health NHS trust on the 21 November 2017 stated the person's skin integrity was 'at very high risk of breakdown' as the person had previous pressure ulcers which had required surgery. There was no risk management plan to accompany this assessment. The care plan risk assessment stated that 'pressure sore care' was 'medium dependency' and 'controlled by medication'. Staff were simply guided to 'keep an eye on pressure areas'. There was no further guidance for staff and no body map in place to assist staff in monitoring this risk. We asked the registered manager about this but they could provide no further evidence this person's skin condition had improved. This meant the person was at risk of developing pressure ulcers.

Some risk assessments were generic and, on occasions, inaccurate. For example, the wording in risk assessments were not personalised and often repeated from person to person. One risk assessment referred to the person as male, when the person was female.

These concerns are a breach of Regulation 12 HSCA RA Regulations 2014 Safe care and treatment.

People told us they felt safe. People's comments included; "Yes, I do feel safe" and "I'd say yes, I am safe". A relative commented, "I do think my grandfather is safe".

People were supported by staff who could explain how they would recognise and report abuse. Staff told us they would report concerns immediately to their line manager or the senior person on duty. Staff were also aware they could report externally if needed. Comments included; "I'd report concerns to my manager, the local authority and CQC (Care Quality Commission)", "I'd tell CQC and the manager" and "Straight to my manager with any concerns". The service had systems in place to report concerns to the appropriate authorities.

People were protected from risks associated with infection control. Staff had been trained in infection control procedures and were provided with personal protective equipment (PPE). An up to date infection control policy was in place which provided staff with information relating to infection control. This included; PPE, hand washing, safe disposal of sharps and information on infectious diseases. Care plans supported staff in relation to infection control. For example, one care plan stated 'anti-bacterial hand wash and kitchen towels' were available in the person's home for staff use. The care plan went on to remind staff to 'regularly wash hands and use PPE'.

We spoke with staff about infection control. Their comments included; "I've been trained and have lots of equipment", "We have everything we need with PPE ([personal protective equipment])". We are well equipped" and "I get good support with all aspects of infection control".

There were sufficient staff deployed to meet people's needs. Staff visit records confirmed planned staffing levels were maintained. Where two staff were required to support people, we saw they were consistently

deployed. People told us staff were mostly punctual and they experienced no missed visits. One person said, "Generally punctual, yes. In fact they have not been late yet". Another person said, "Yes they are usually punctual. I do get a call if they run late". We noted whilst the registered manager monitored late calls, no system existed to analyse data to look for patterns and trends. The registered manager told us, "I intend to put a system in place to do this". People and records confirmed there had been no missed visits.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions.

The service had systems in place to record accidents and incidents. The registered manager told us no incidents had occurred and records confirmed this.

At the time of our inspection people's relatives support them with medicines. However, staff and records confirmed that they had been trained and assessed to safely administer medicines, if required. One staff member said, "I have been trained and assessed by the district nurse".

Good

Is the service effective?

Our findings

People's needs were assessed prior to accessing the service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person's care plan stated 'likes watching TV'. Another stated the person's main interest was reading. Staff were aware of people's preferences.

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person's condition could fluctuate and meant sometimes they could not hold their cutlery. Staff were guided to monitor the person's condition and ask if they needed support with eating. This person told us, "Oh I think they do know what they are doing. I find them really good". Staff we spoke with were aware of, and followed this guidance.

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they received an induction and completed training when they started working at the service. This training included safeguarding, moving and handling, dementia and infection control.

Staff also shadowed an experienced member of staff before being signed off by the registered manager as being competent to work alone. Staff spoke with us about their training. Staff comments included; "The training was very good" and "I have been given a lot of information and the time to take it in and learn. I also shadowed an experienced colleague". Training records were maintained and we saw planned training was up to date. Where training was required we saw training events had been booked.

Staff told us and records confirmed staff received support through regular supervision (a one to one meeting with their line manager). Staff comments included; "I am supported 100%. I get daily checks on how I am doing", "I think I am pretty well supported" and "I do get good support from both spot checks and supervision". These measures ensured staff had the skills, knowledge and experience to deliver effective care and support.

We discussed the Mental Capacity Act (MCA) 2005 with the registered manager. 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. The registered manager was knowledgeable about how to ensure the rights of people who lacked capacity were protected. On the day of our inspection no one at the service lacked capacity to make any decisions.

Staff demonstrated an understanding of the MCA and how they applied its principles in their work. Staff comments included; "This is about client's capacity to make decisions. It's also to do with consent so I make sure I give clients choices" and "I have been trained. This is all to do with people's decisions and choices. At

the moment all our clients have very good capacity to make their own decisions".

The service sought people's consent. Care plans contained documents evidencing the service had sought people's consent to care. These were signed and dated by the person or their legal representative. Staff told us they sought people's consent. One staff member said, "I never do anything without the client's permission".

Most people did not need support with eating and drinking. However, some people needed support with preparing meals and these needs were met. People either bought their own food or families went shopping for them. People had stipulated what nutritional support they needed. For example, one person had stated in their care plan they only needed support to eat if they were 'too weak to eat independently'.

The service worked closely with other professionals and organisations to ensure people were supported to maintain good health. For example, one person received regular visits from the district nurse to monitor their condition. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included people's GPs, speech and language therapists (SALT), opticians, dentists NHS Trusts, social services and district nurses. Details of referrals to healthcare professionals and any advice or guidance they provided was recorded in people's care plans. Information was provided, including in accessible formats, to help people understand the care available to them.

Good

Is the service caring?

Our findings

People told us they benefitted from caring relationships with the staff. Comments included; "They [staff] are alright, they really do care" and "I would say they are very caring and I think we are developing a good relationship. It is ongoing".

Staff spoke with us about positive relationships at the service. Comments included; "Yes we do care, I engage in conversations with my clients", "Oh I do have good relationships with them [people]" and "I really enjoy my work, the clients are great".

People were involved in their care and kept informed. Daily visits schedules and details of support provided were held in people's care plans. For example, one person's schedule detailed how they should be hoisted out of bed and given a bath. Details of other specialist support relating to a specific condition were also listed. Schedules of support were updated in line with care reviews informing both people and staff of the support needs. Daily notes evidenced visiting schedules were followed and consistently maintained. People told us they were involved in their care. One person said, "Yes I do feel involved, I certainly have my say". Another person said, "Oh yes I am involved. I believe I am in charge".

People's independence was promoted. Care plans guided staff to support people to remain independent. One person said, "I am independent, carers are good with this. There are no issues". We spoke with staff about promoting people's independence. Staff comments included; "I encourage clients to do what they can. I give choices so they feel in control" and "I give choices and explain to them what needs doing and let them do what they are able to do". This practice promoted people's independence.

People were treated with dignity and respect. When staff spoke about people to us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful. People were addressed by their preferred names. One staff member spoke about dignity and respect. They said, "I always close doors and draw curtains to keep personal care private and I keep clients covered up".

We spoke with people about emotional support. One person said, "The support is there but I don't bother with that sort of stuff". Another person said, "I've no real emotional support needs". People's emotional support needs were assessed and recorded in their care plan. Of those care plans we reviewed, no one had identifiable emotional support needs recorded. Staff recorded people's emotional states on daily communication sheets held in people's care plans. For example, one staff member had recorded 'on arrival found [person] to be very happy'. Another had recorded 'relaxed and watching TV'.

The service ensured people's care plans and other personal information was kept confidential. People's information was stored securely at the office and we were told copies of care plans were held in people's homes in a location of their choice. Computers holding personal information were password protected and a confidentiality policy was in place and gave staff information about keeping people's information confidential.

Good

Is the service responsive?

Our findings

People told us they were treated as individuals. One person said, "They do treat me as an individual. We have good friendly conversations but they don't make any assumptions about me". Another person said, "Yes they do treat me as an individual". One relative commented, "[Staff member] is brilliant. He gets on so well with [person]. They swap DVDs and stories and seem to have a lot in common".

People were assessed to ensure their support plans met their individual needs. Staff were knowledgeable about people's needs and told us they supported people as individuals, respecting their diversity. This ensured people received personalised care. For example, one person's care plan noted the person had requested 'please give me a wash in the morning followed by a shave'. Staff were then guided to ask how the person was feeling as their condition and ability to be independent could fluctuate. Staff followed this practice which meant this person's daily needs were met.

People had access to information in a way that was accessible to them. People were able to read their care plans and other documents. Where people had difficulty, we were told staff sat with people and explained documents to ensure people understood. Where appropriate, staff also explained documents to relatives and legal representatives. Staff were also informed of people's preferred methods of accessing information. For example, one care plan noted the person 'wears glasses to watch TV'. Staff ensured the person's glasses were clean and accessible. Another person's speech was 'unclear'. Staff were guided be patient, maintain eye contact and 'ask the person to repeat if they did not understand'. The registered manager told us, "If any client needs large print or alternative languages we can provide information for them".

People's diverse needs were respected. Discussion with the registered manager showed that they respected people's different sexual orientation so that gay and bisexual people could feel accepted and welcomed in the service. The services equal opportunities policy covered all aspects of diversity including race, sex, sexual orientation, gender re-assignment and religion. The policy also stated 'the service, management and staff would be responsive and sensitive' to people's diversity needs. Records showed staff had received training in equal opportunities and diversity.

We spoke with staff about diversity. Staffs comments included; "The client's needs come first, number one. Their choices and preferences not mine" and "I have been trained. It makes no difference to me about people's backgrounds. To me everyone is equal".

People knew how to raise concerns and were confident action would be taken. One person said, "I know how to complain and they have reacted well in the past". Another person said, "I do know how to complain. If I did I think they would do something about it". The service had systems in place to record and investigate complaints. The complaints policy was available to people in their care plans kept in their homes. The service had no complaints recorded.

On the day of our inspection, no one was receiving end of life care. Where people approached the end of their life the service worked with healthcare professionals and the person's family. We saw staff had been

trained in palliative care and these staff were deployed to support people at end of life. The service had strong links with a local hospice and staff liaised with end of life specialists to ensure people experienced a dignified, pain free death.

The registered manager sought people's opinions through telephone monitoring calls and visits to people's homes. Opinions were also sought through a recent survey, the results of which were positive with no actions arising from the survey. The registered manager said, "I intend to collate all the information from visits, calls and surveys and I am planning a further opinion based survey for the near future. This will help us grow and improve".

Requires Improvement

Is the service well-led?

Our findings

There was 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 registered manager monitored the quality of service provided. Regular audits were conducted to monitor and assess procedures and systems. For example, care plans and staff training were regularly monitored. However, these systems were not always effective. Care plan monitoring had not identified our concerns relating up to date and accurate risk assessments. We also found there was no system in place to analyse information obtained through monitoring, and drive continuous improvement. We raised these issues with the registered manager who said, "I will put a system in place immediately to address this. I am currently working on a new computer data base that will allow me to do this". We could find no evidence that these concerns had a negative impact on people using the service.

People we spoke with knew the registered manager and felt the service was well run. One person said, "As it goes I think it's well run. I know what's going on and they explain things to me which is good". Another person said, "Yes I do know her [registered manager]. She is good, she gives advice to the staff and from my observations the service is well run". One relative commented, "In many ways, yes, it seems well organised".

Staff told us they had confidence in the service and felt it was well managed. Comments included; "[Registered manager] is easy to get on with, friendly and approachable. I would say we are well run, considering how small we are", "She [registered manager] is serious about care, very hands on and she gets involved. I think this is well run, she is very approachable and supportive" and "She [registered manager] is strong, intelligent and approachable. 100% well run, oh yes. There is no culture of blame here".

The service had a positive culture that was open and honest. Throughout our inspection the registered manager and staff were keen to demonstrate their practices and gave unlimited access to documents and records. The registered manager spoke openly and honestly about the service and the challenges they faced as a new, small service.

We spoke with the registered manager about their vision for the service. They said, "I want my clients to be happy, safe and treated as individuals. I want us to grow as a service and hopefully move to a large office location". Our findings detailed in the other areas of this report demonstrated that the staff were currently working in accordance with this vision.

The registered manager worked in partnership with external agencies such as GPs, district nurses and social services. The registered manager had also joined a care provider forum. They said this was to, "network with other managers and providers and to get new ideas".

There was a whistle blowing policy in place that was available to staff across the service. The policy

contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.