My Life (Carewatch) Limited

My Life Living Assistance (Christchurch)

Inspection report

2-3 Fairmile Parade
Fairmile Road
Christchurch
BH23 2LP

Tel: 01202474300
Website: www.carewatch.co.uk

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20 September 2018

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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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on the 19 and 20 September 2018 and was announced. When we last inspected the service in January 2017 we found a breach in regulation. Systems and processes were not being operated effectively to prevent abuse of people as information had not been shared with the appropriate agencies. We received a provider action plan in April 2017 telling us they were now meeting the legal requirement. At this inspection we found that improvements had been made.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service primarily to older adults. At the time of our inspection there were 68 people receiving a service from the agency. The service had been registered for providing nursing care but was not providing this at the time of our inspection.

The service had a registered manager. 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 present during our inspection but arrangements were in place for senior staff to provide any information needed.

The service had failed to comply with their condition of registration as they had moved address in January 2018 before their current location had been registered with the Care Quality Commission. The new address was registered with CQC on the 10 August 2018.

People and their families described their care as safe. Staff had been trained to recognise signs of abuse and understood their role in reporting any concerns both internally and to external agencies. Staff had also completed equality and diversity training and respected people's individual lifestyle choices. Assessments had been completed that identified risks people lived with and staff understood the actions needed to minimise the risk of avoidable harm including preventable infections. Medicines were administered safely by trained staff who regularly had their competencies checked.

Staff had been recruited safely ensuring they were safe to work with vulnerable adults. Staffing levels met people's needs with office staff also trained to provide care when needed. Effective processes were in place to manage unsafe practice. Incidents, accidents and safeguarding's were used to reflect on practice and lessons were learnt when things went wrong.

Assessments had been carried out prior to a person receiving care and support and this information had been used to create person centred care plans reflecting the persons care needs and choices. People had their eating and drinking needs understood and met as staff were knowledgeable about peoples likes, dislikes and routines. People were supported to access a range of health and social care services when needed, including district nurses and specialist mental health workers. People had an opportunity to be involved in end of life planning and had their cultural and religious diversity respected.

Staff had completed an induction and had ongoing training and support that enabled them to meet people's needs and carry out their roles effectively. Opportunities for professional development included staff completing national diplomas in health and social care.

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. A complaints process was in place and people felt if they raised concerns they would be listened to and actions taken.

People and their families spoke positively about the care team describing them as kind and caring and told us they felt involved in decisions about their care. People had their privacy, dignity and independence respected. Staff had a good knowledge of people, their past histories, hobbies and interests and had the skills to meet people's individual communication needs.

The culture of the service was open and transparent which enabled people, their families and staff to be involved and share views about the service. Robust quality assurance processes were in place that effectively monitored service delivery and regulation compliance highlighting areas of improvement and achievement. Links with other organisations such as Skills for Care meant that the service was able to keep up to date with best practice guidance and new innovations.

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 supported by staff who had been trained to recognise signs of abuse and understood their role if abuse was suspected.

People had their risks understood and actions were followed by care staff to prevent avoidable harm.

Staff had been recruited safely and staffing levels met the assessed needs of people.

People had their medicines administered safely.

People were protected from avoidable infections.

When things went wrong lessons were learnt and shared with people and the staff team appropriately.

Is the service effective?

Good

The service was effective.

Assessments were completed identifying people's care needs and choices and reflected people's diverse lifestyles.

Staff received and induction and ongoing training and support enabling them to carry out their roles effectively.

People had their eating and drinking needs understood and met.

People had support accessing health and social care professionals when needed.

People were supported to make choices in line with the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and had a good knowledge of people, their history and communication skills.

People were able to express their views about the way they wanted to receive care.

People had their privacy, dignity and independence respected.

Is the service responsive?

Good

The service was responsive.

People received person centred care which was regularly reviewed and responsive to changes.

People had information about the complaints process and felt if needed would be able to report concerns.

People had opportunities to be involved in end of life care planning which respected their choices and wishes.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had failed to comply with a condition of registration as they had moved address in January 2018 before their current location had been registered with the Care Quality Commission.

The service had an open and relaxed culture enabling good communication, teamwork and involvement in service development.

Staff understood their roles and responsibilities.

Systems and processes were in place to engage and involve people, staff and the local community.

Quality assurance processes were effective in monitoring service delivery and driving improvements.

Partnerships with other agencies enabled best practice and supported development of the service.

My Life Living Assistance (Christchurch)

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 checked 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.

The inspection took place on 19 and 20 September 2018 and was announced. The provider was given 24 hours' notice. This was so that we could be sure the registered manager or a representative was available when we visited and that consent could be sought from people to receive home visits from the inspector.

The inspection was carried out by one inspector on both days. Phone calls to people were completed by 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. They had experience in dementia care and care at home services. We visited the office location on the first and second day to see members of the office and management teams and to review care records and policies and procedures.

Before the inspection we reviewed all the information we held about the service. This included notifications the service had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive.

We had not 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. We gathered this information at inspection.

We visited two people and discussed their experience of the service. We had telephone conversations with seven people and eight relatives. After our inspection we spoke with a community nurse about their experience of the service.

We spoke with the director of operations, group head of quality, head of quality and training, two quality officers, administrator, care co-ordinator and seven members of the care team.

We reviewed five people's care files, medicine records, three staff files, minutes of meetings, complaints and audits.

Good

Is the service safe?

Our findings

When we last inspected the service in January 2017 we found a breach in regulation. Systems and processes were not being operated effectively to prevent abuse of people as information had not been shared with the appropriate agencies. At this inspection we found that improvements had been made.

People and their families spoke positively about the care and felt safe. One person told us "I feel safe with them(staff), when you live alone it's nice to have the company". Another told us "I am very safe with them(staff) and they are also very kind and caring". All staff had completed safeguarding training and understood their role in reporting any concerns including reporting poor practice. Staff were provided with work mobile phones and had access to a quick reference application for safeguarding information. When safeguarding concerns had been identified, these had been shared appropriately with external agencies such as the local authority and CQC. People and staff were protected from discrimination as staff had completed training in equality and diversity and recognised and respected people's individuality.

Assessments had been completed that identified risks to people's health and safety and staff understood the actions needed to minimise risks of avoidable harm. One person had a risk of falls. The risk assessment included environmental factors such as positioning their telephone and walking aid next to them. Another person had an alarm pendant so they could call for assistance if they fell. Staff carried out a monthly tests to ensure it was working correctly. Another person required assistance with moving and transferring and an occupational therapist had completed a plan providing details of how staff needed to do this safely.

Where people had a risk of skin damage, specialist pressure relieving mattresses had been provided by third parties. Not all staff we spoke with were familiar with how to ensure they were working correctly. We discussed this with the quality officer who during our inspection organised pressure equipment training in October for care staff. Records demonstrated changes to risks were reviewed with people and their families and their views, freedoms and choices were respected.

People were supported by enough staff to meet their needs safely. Staff whose main role was office based had completed training which enabled them to provide care to people. The care co-ordinator explained "I care as well. It's nice to have that element; to be on the ground as well". This meant there was flexibility for covering staff absences. Staff had been recruited safely including checks with the disclosure and barring service to ensure they were suitable to work with vulnerable adults. Processes were in place that had effectively managed poor practice.

People had their medicines administered safely. One relative told us "They give (relative) tablets daily and write it all up". A care worker told us one person preferred routine when taking their medicines and explained "They(person) know how many to take and staff hover and watch (before signing to record administered)". We observed a care worker checking a person's medicines on their return from a hospital admission to ensure the medicine administration record remained correct.

People were protected from avoidable risks from infection as staff had completed infection control and food

hygiene training. We observed staff wearing gloves and aprons appropriately.

Lessons had been learnt when things went wrong. Incidents, accidents and safeguarding were seen as a way to improve practice and action had been taken in a timely way when improvements had been identified. Following a safeguarding the group head of quality explained actions taken. These included guidance for supervision and staff meetings. They needed to include specific questions to ascertain if when supporting people with dementia the care worker needs further training, support or breaks.

Good

Is the service effective?

Our findings

People and their families had been involved in an assessment which had been used to gather information about their care needs and lifestyle choices. The assessment included information about a person's medical history and how this impacted on the person's life and support needs. The information had been used to create person centred care plans which had been developed in line with current legislative standards and good practice guidance.

People told us staff were skilled in their roles. One person told us "They(staff) seem to know what to do". Another told us "If our regulars(staff) are away the cover girl is always well trained."

Staff had completed an induction and on-going training that enabled them to carry out their roles effectively. Induction included meeting the standards of the Care Certificate. The Care Certificate sets out common induction standards for social care staff. It had been introduced to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care.

A care worker told us about dementia training they had completed. "It helped me understand the different types of stages of dementia". They went on to explain "If somebody asks me the same question they asked two minutes ago perhaps I will answer in a different way to help them take it in a bit better". Training programmes had been created for senior roles. Quality Officers completed a five day course that included assessing and managing risk, person centred care planning and auditing.

Staff told us they felt supported in their roles. A care worker told us "The office are great. The team are always on the end of the phone". Staff received three monthly supervision carried out either in the office or in people's homes. Records showed us these included checks on infection control, dignity and safeguarding. Staff had opportunities for professional development including diplomas in health and social care.

People had their eating and drinking needs understood by the care team. We were told of one person who had a dementia and often said they didn't want to eat. A care worker said, "I know they like scrambled egg and when they see it they do eat it". We observed a care worker providing breakfast options to a person and respecting their preferred routine and choices.

The service worked with other organisations to ensure people had effective care. This included community district nurses when people needed support with diabetes or wounds, community mental health teams when people needed support with their dementia and palliative care nurses when people were receiving care at the end of their life. One person had returned from a hospital stay and we observed staff checking the discharge details for any new instructions or changes in the person's care. Each person had a summary sheet of key information to be shared between services which included key care needs, medicines and emergency contacts.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found the service was working within the principles of the MCA.

A senior care worker told us "If we have somebody we feel have issues with their memory we organise with the family a GP appointment so they can be referred to the memory nurse. We then get a letter to say capacity has been assessed". One person had a medicine administered covertly. Records showed us the person's GP had been involved in the best interest decision. We observed staff respecting people's choices and obtaining consent before supporting people. Examples included whether to have a wash or a shower or whether they wanted breakfast before or after. A relative told us "They do not restrict (relative) with anything, they carry out instructions as needed."

Care records showed consent had been obtained appropriately for photographs, personal care and administration of medicines. Files contained copies of legal arrangements for people and staff understood the scope of decisions they could make on a person's behalf. This meant people were having their rights upheld.

Good

Is the service caring?

Our findings

People and their families described the care team as kind and caring. We observed one person say to a care worker "You're a kind lady and you are worth a lot". One person told us "The best you can get as to caring, they give me choices such as whether I prefer a bath, shower or wash". Another said "Most definitely they are caring. They always ask me if there is anything different and provide all the care we need". A relative told us "They are caring, they have a laugh with (relative). I just let them get on with it, they know what to do."

We observed a relaxed and friendly relationship between people and care workers. Staff respected lifestyle choices people had made in their homes. People laughed and smiled with the care team and engaged in meaningful conversation relevant to their day.

The care team had a good knowledge of people, their backgrounds, histories and diversity. A care worker explained "Everybody we see have different backgrounds. You get chatting to people and it's good to hear their stories".

People had their communication skills understood. One person was hard of hearing and a care worker explained "I talk at a level so that they can see as well as hear what I'm saying. For lunch I visually show them and they can pick rather than going through a long list".

People felt involved in decisions about their care. One person told us "They always ask me if there is anything different and provide all the care I need". One person was living with a dementia and the care worker explained how they involved them in decisions. "(Name) isn't always keen about having their creams applied. I always give (name) the option of which of the creams they would like first; so that (name) is in control of it".

A senior care worker explained how one person had needed hospital treatment and on their return, was anxious about receiving personal care. A care worker who had undertaken the same treatment was able to be matched and supported them with their recovery.

People told us the care team respected their privacy and dignity. Information had been gathered from people about access to their homes. Examples included a person requesting the staff knock, open the door and shout their name before entering. We observed care staff calling people by their preferred name and talking to people in a respectful manner.

People were supported to maintain their level of independence. A care worker explained "(Name) has things he can do and can't do. We take (name) a bowl (to his chair) and he shaves. We try to find compromises to help (name) remain independent".

Staff had been updated on the new data protection standards and understood their role in maintaining people's confidentiality.

Good

Is the service responsive?

Our findings

People had care plans which reflected their personal care needs and choices and were reviewed at least monthly. Care staff could demonstrate a good knowledge of the actions needed to meet people's care needs and choices. One person told us "I have a care plan and I was involved with it. The staff do know what is in it". A care worker told us "The care plans include recognising diversity and everybody's foibles".

People were involved in planning and reviewing their care. We read a review where one person had started to need help with oral care and this had been added to their care plan. Care staff completed a daily diary following each visit. Details were descriptive and included information about medicines, eating and drinking, a person's mood, conversations and anything that needed sharing with the next care visit. Changes to people's care needs were shared with staff through messages sent via telephone messaging, emails or telephone calls.

Information about people's medical conditions had been included in people's care files. It included details about how the condition could impact on the person and signs and symptoms of change. An example was a person with a vascular dementia and described how increased confusion may indicate other health problems such as an infection.

The service met the requirements of the Accessible Information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Accessible information assessment forms had been introduced and had been included in staff induction. The group head of quality told us "We are looking at voice activated care plans for people. A pilot is also planned for communication aids such as visual pictorial boards. If a person is registered blind we can get any information provided in braille".

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government and social care ombudsman. One person told us "I have complained about (continence aid) and they say they will incorporate it into the training". Records demonstrated that complaints had been investigated and outcomes shared with people, their families and staff where appropriate.

People had an opportunity to develop care and support plans detailing their end of life wishes which included any cultural requirements and decisions on whether they would or would not want resuscitation to be attempted.

Requires Improvement

Is the service well-led?

Our findings

The service had failed to comply with the conditions of registration because they had moved address before their current location had been registered with the Care Quality Commission. The new address was registered with CQC on the 10 August 2018.

People told us the service was well managed. One person said "It is well managed and the manager checks regularly to see how things are going. We get a rota by post and e mail". Another told us "It's well managed and they ring every now and then to see how it's going. Sometimes they come round and do a review. We get a rota weekly". Staff described an open and inclusive culture. One told us "(registered manager) makes you feel valued. (Registered manager goes out of (their) way". Another told us "I feel if I chat with (registered manager) she is listening". We observed relaxed, chatty, professional relationships between care staff and the office and management team.

Staff had a clear understanding of their roles and responsibilities and understood the level of decision making appropriate to their role. Examples care staff described included reporting safeguarding concerns, changes to a person's health and medicine queries. The care team told us that office staff were always helpful and supported with calling GP's and families when needed including out of normal office hours. A care worker told us "You never feel alone. There is always somebody at the end of the phone to help".

The registered manager's professional development included attending a ten day in-house management course with subjects including people management, employment law and quality.

People, staff and the community had opportunities to be engaged with the development of the service. A care worker told us "Staff meetings are helpful. We discuss medicines, phones, uniforms, rotas and feedback about the staff". Minutes of staff meetings included sharing information with staff about quality audits including areas identified as requiring improvement and team achievements.

The organisation shared information and news stories about the staff with people through a regular newsletter. An open invitation had been extended to families and the local community to attend an event held by one of the organisations nurses. It had provided an opportunity to have a questions and answers session about dementia.

A range of quality assurance processes were in place that had been effective in highlighting and actioning areas requiring improvement. In April 2018 a telephone monitoring audit highlighted 12% of people had not been aware of how to make a complaint. This led to staff checking and ensuring every person's file had a copy of the complaints policy.

Learning had also been captured from other services in the group and used to improve service delivery. An example included reviewing medical information in people's files and including how health conditions can impact on a person in their day to day lives.

The staff team worked with other organisations and professionals to ensure people received good care in line with best practice guidance. These included the National Institute for Clinical Excellence, Skills for Care and the Alzheimer's Society.