Careline The Agency for Carestaff Limited

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Inspection report

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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

Overall summary

This inspection was completed on 1 and 5 October 2015. Careline The Agency is a domiciliary care service (DCS). A DCS is a provision that offers specific hours of care and support to a person in their own home. We announced this inspection to be sure that someone would be in the office during the inspection process.

We found that at the time of the inspection a registered manager was 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.

Summary of findings

People were kept safe by appropriately trained and competent staff. Sufficient numbers of staff were involved in delivering the care packages of individual people. These were matched in accordance with needs, knowledge, age, hobbies and general personality. Systems were employed by the service to recruit suitable staff to work with people. Staff were trained in how to keep people safe by being aware and observant of signs of abuse, and how to report concerns promptly.

A rolling training schedule ensured that staff were receiving updated and relevant training to meet the care and support needs of the people. The induction programme took components from skills for care, and was delivered through face to face training, allowing staff the opportunity to discuss components of the training with a trainer. Specialist training was provided for those staff who would be working with people who required specific input. Employment, safety and competency checks were completed prior to staff being allowed to work independently with people.

We were told by people and their relatives that they were happy with the service that they were receiving. The staff were caring in their manner, and ensured that they maintained the person's dignity at all times. Care plans were reflective of how support needed to be delivered incorporating the views of the person and their family. Continuing audits and reviews involving people and their relatives meant that they were involved in the evolving care document.

People were supported with their medicines by competent and suitably trained staff. Medicines were managed safely and securely. Medication administration records (MAR sheets) illustrated correct administration and were audited weekly. Where 'as required' (PRN) medicines were prescribed, guidelines accurately recorded how and when these medicines should be administered.

Those individuals who were unable to make specific decisions related to their care and support had their legal rights protected. The care plans showed that when decisions had been made for people about their care, where they lacked capacity, these were done in their best interest.

The service was audited and monitored by the management on a continual basis. Monthly internal audits, feedback from people was sought every month and 12 weekly as well as annual quality assurance audits, enabled the service to develop action plans. However, the outcomes of the action plans were not always recorded. We found evidence of compliments and complaints that highlighted how the management worked transparently.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were kept safe with a robust recruitment procedure. They were matched with staff who shared similar interests and had relevant experience and knowledge in the areas that the person required.

Procedures to protect people from abuse were in place. Staff had relevant training and understood how to implement this should safeguarding be required. Policies related to reporting concerns were available in the office should staff need these to refer to.

Good

Is the service effective?
The service was effective.

People received support on time from staff involved in their support.

Staff received relevant training, supervision and appraisals to help them work more effectively.

People and relatives (where appropriate) were involved in developing the care plans. Where people did not have capacity to make decisions or were too young to make decisions, support was sought from family or healthcare professionals, as per legal requirements.

Good

Is the service caring?
The service was caring.

People's individual needs and preferences were well documented. Staff were described as being respectful, maintaining the dignity and privacy of people. Staff worked well with people, providing an explanation when supporting them.

Staff remained with people when a risk to their health was noted, irrespective of whether this exceeded the agreed hours of support.

Good

Is the service responsive?
The service was responsive.

Care plans were reviewed regularly to ensure they were reflective of people's needs. Where applicable changes were made to make certain that people's views were understood and reflected in the plan.

A complaints system was in place that allowed staff and people or families to confidently make a complaint.

Good

Is the service well-led?
The service was well-led.

People and staff stated that the management was both approachable and open.

Processes of auditing had been put into place to continually monitor the quality of the service. These were not always appropriately actioned reflecting what actions had taken place to improve the service.

Good

Careline The Agency for Carestaff

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 1 and 5 October 2015 and was announced. The provider was given 24 hours' notice because the location is a domiciliary care service, and we required a senior member of staff to be available in the office to assist us with the inspection process.

The inspection was completed by one inspector. Prior to the inspection we gathered and reviewed information sent to us by the provider in the PIR (Provider Information Return), through local authority reports and notifications.

Notifications are sent by the provider to the Care Quality Commission to advise us of any significant events in relation to the service. We further contacted the local authority care commissioners for feedback related to this service.

The care plans, records related to health, and all documents related to support were seen for six people. A selection of records specific to the management of the service were also looked at. This included, staff files, supervision records, quality assurance audits, complaints records, recruitment protocols. Records for six staff were viewed during the inspection process.

We spoke with one person and four families of people who were supported by Careline the Agency for Carestaff to gain their views on the service they received. We further spoke with four staff, including the registered manager, the senior care co-ordinator and two care support workers.

Good

Is the service safe?

Our findings

Recruitment processes were in place to keep people safe. These included obtaining references for staff in relation to character, behaviour in previous employment and a Disclosure and Barring Service check (DBS) were obtained. A DBS allows employers to establish if an applicant has any criminal convictions that will potentially prevent them from working with vulnerable people. The service had an internal policy whereby all staff were required to have their DBS status checked annually. Those staff who had not subscribed to the DBS update service, were required to have a new DBS every year. A checklist system was implemented by management to ensure staff recruited were safe to work with people. Competency checks were completed to ensure staff were safely and effectively carrying out all duties – for example medicine administration. This included, declaration of health and fitness, interview notes, CVs and character checks. We found that on day one of the inspection not all staff files had gaps in employment explained and full employment history. However by day two of the inspection, the registered manager had put systems into place to obtain all the missing information.

People and their families reported they felt they were kept safe. One relative reported "[staff name] she's consistent and feels safe with her. Absolutely safe." Staff had a full understanding of safeguarding and the whistleblowing procedures. They were able to describe signs of potential abuse, as well as accurately detail the various types. All staff underwent comprehensive training, which included safeguarding. Refresher courses were arranged for staff whose training was due to expire, ensuring that a rolling programme of training was invested in. When asked what they would do if potential abuse was reported or witnessed, staff told us that the registered manager would be told. If the abuse included the manager, then the local safeguarding team, local authority (commissioners), police and CQC would be contacted. Staff were confident to report abuse and felt it would be appropriately and effectively dealt with by management.

Risk assessments were completed to ensure that people were able to engage in daily living tasks and activities, without compromising their safety. However, risks to staff in delivering the care package had not been assessed. For example, in one instance risk assessments to safeguard staff had not been written. The risk related to administration of medicines, where the maximum dosage was unknown by staff, although discussed within a multi-disciplinary framework –including GPs, human rights solicitors, failed to protect staff, as the person was telling staff what medicine to give and the dose. We discussed this with the registered manger during the first day of inspection. By day two, appropriate measures were taken to keep staff safe whilst administering medicines. We found that all other records for administration of medicines were appropriate. Medication administration records (MAR sheets) were used to record when medicines were offered, taken or refused. These were audited frequently to ensure no errors were made by staff.

'As required' (PRN) medicines required a protocol that provided staff guidance on when the medicine should be given, and what action needed to be taken before medicines were offered. This was to make sure that medicines were only given when necessary. Staff were able to correctly describe when PRN medicines should be given. Some people had the capacity to inform staff when they required pain relief medicines, whilst other people relied on staff or relatives to make this decision. By having this procedure in place, the service was able to keep people safe from over usage of medicines.

Incidents and accidents were monitored to see whether a trend could be found. Systems were in place to focus on this, and alert the registered manager. If a trend was noticed, we were told by the manager, that written guidance was put into place to prevent a similar incident from occurring. This was then monitored for effectiveness, to ensure people were being kept safe. If appropriate, a similar approach may be applied to another case that illustrated similar trends.

Good

Is the service effective?

Our findings

A comprehensive induction programme was offered to all new staff who joined the service. This included all service mandatory training, with additional specific teaching focused on the people they may provide support to. For example, if support was going to be offered to a person who had an percutaneous endoscopic gastrostomy (PEG) feeding tube, staff received certified training and competency checks from a qualified nurse to illustrate they were knowledgeable in PEG feeding, prior to supporting the person in this area. This is when a person requires feeding through a tube inserted in the abdomen. An effective way of ensuring that people were given control and choice of who supported them was when Staff were matched and introduced to a person through shadow shifts. People or relatives were asked to sign to say they were happy for the staff to become regular, before shadowing was drawn to a close.

The service had a computer system in place which highlighted when training was due to be renewed for staff so that it remained in date and effective when supporting people. This alerted the manager to book staff on the rolling training programmes offered by the service. This method of monitoring meant that staff knowledge and skills were continually updated. The service was incorporating the Skills for Care "Care Certificate" training into the corporate training. This is the recognised training within adult social care, and provides a standard within provisions providing care.

All staff received training in the Mental Capacity Act 2005 (MCA). Staff were able to correctly identify that people's capacity needed to be assessed in relation to making decisions. The MCA is a legal framework that identifies when a decision can be made on behalf of a person who may lack mental capacity to make a decision for themselves. Staff were able to provide examples of how they would ask and assess whether a person was able to make a decision. For example, one staff reported that a person they supported would nod if they were ready to have personal care. The care plan for this person contained information from the family which confirmed this was how consent was given. . Care plans also highlighted how choice was important when supporting people. One relative reported staff: "Always respect choice and dignity. Take time when supporting [name] with eating". This showed that personalised care was provided that catered to meet the needs of the person, rather than being task focused.

Nutritional profiles were developed for some people who required support specifically in this area. These were often discussed within a larger professional capacity, with specialist involvement, for example with a dietitian, Speech And Language Therapist (SALT), Occupational Therapist (OT). Monitoring systems to record the food eaten were in place. However, these did not always state why food was monitored or follow through with actions to be taken if concerns were identified. However, new recording systems were introduced by day two of the inspection that requested information specific to the needs of the person. This illustrated effective monitoring systems were carried out by the service.

Regular supervision was provided to staff. This gave the member of staff and the line manager the opportunity to discuss any issues that may have arisen, as well as areas where the member of staff excelled. Where necessary any additional training or support was decided within these sessions. Appraisals took place annually. Both were perceived as useful processes by management and staff. One member of staff stated "I use these to help me develop and learn about my role. I want to do well in my job".

Good

Is the service caring?

Our findings

One family member reported, "I'm very pleased with them. The care I can't fault it". This was unanimously reported by all relatives and people spoken to during the course of the inspection. People reported they were treated with dignity and care. One family member (parent) went on to say, "Yes very caring. They treat [name] caringly. They work at teaching her right and wrong." The registered manager and the senior care co-ordinator advised that during the induction and training, significant emphasis is placed on the role of the support worker, as being there to support the client to achieve their personal goals. The training reinforced that staff are working within the client's homes, and irrespective of whether they need support, their dignity, independence and choice are to be maintained at all times.

We found that people were involved in decisions pertinent to the care and support they received. One family member reported "I was involved in writing the care plan". Whilst one staff took the lead with each person, a team was delegated to work with each client to maintain consistency. The team then developed the care plan in conjunction with the person or family members to ensure the person was the centre of the support. The care plans were reviewed by the team, with feedback generated to discuss with the person or with the family during reviews.

The consistent team of staff was developed by focusing on their knowledge and skill base related to the person's needs. In addition, factors such as hobbies and interests were matched, so that staff could develop a meaningful relationship with the person, as opposed to being task orientated. For example, one person attended a theme park once a week, and needed staff who were able to assist with personal care to further enjoy rides, not be afraid of heights, and enjoy good health. Another relative of another person stated "It's nice that we have them [staff]. They're very helpful – that's the main thing when caring… we look forward to seeing them".

Signed sheets illustrated that staff had read all documents related to the support they were to provide to people. These were maintained in the records kept within the secured files at the service location. Copies of the care plan were also kept in people's homes. This meant that people and their relatives could be reassured that appropriate care and support was being provided, as agreed in the care plan.

People were treated with respect and dignity. Staff were able to describe how they ensured this in their practice. We were told that people were addressed in their preferred manner, and supported how they chose to be cared for. One relative stated they had used one primary member of staff for over 8 years. They stated that "although our daughter is non-verbal, we would know if she was unhappy. [name] always respects her choice, always treats her with dignity… they're interested in her".

Good

Is the service responsive?

Our findings

Each person had their needs assessed prior to any support being offered. If the service felt able to successfully offer support a further meeting would be arranged where the care plan and risk assessments were developed with people and their families. Each bespoke care plan contained relevant information about the person's life, family, likes, dislikes and how they like things done. The care plans provided step by step guidance for staff on how to carry out tasks when working with each individual person.

These were reviewed as the needs of the person changed or every six months to annually dependent on the level of involvement by the service. One family member stated, "We have an annual review with the managers. We inform them of our point of view. We're very happy with them". Another family member stated, "we were involved in writing the original care plan and are involved in reviewing it too". Both people and staff felt that the care plans were appropriately updated to facilitate good continuation of care.

The service was responsive in updating support documents with the changing needs of a person. For example in one care file, the recording systems changed as the needs of the client intensified. Recording sheets were amended to allow staff to correctly detail where additional time and support mechanisms were being employed. This allowed the service to discuss the person's case with the commissioners so that the care package could be responsive to changing needs.

In one instance, records illustrated how staff had responded appropriately to a person's changing immediate health needs. The staff accompanied the person to hospital, remaining with them until family arrived. The family member then requested additional support in the hospital, and so the staff remained with the person and their family until they were out of immediate danger. The support package was on hold whilst the person was hospitalised, resuming the original hours of support upon discharge. This was an example of how the service responded to the needs of the person, providing additional support and reducing support when not required.

During the assessment phase, people and their families were provided with information on how to complain. We found that people and their families were aware of what to do if they were unhappy with any part of the service they received. The complaints log was reviewed, and illustrated that complaints were appropriately dealt with. The registered manager further described how complaints "don't need to be in writing to be a complaint. They are a learning curve". She described how it was important to keep the complainant up to date with the investigation and outcome when dealing with any concerns. People and families were confident in raising concerns with the service and management. One person stated, "I would directly ring Careline if I had a complaint. But I don't".

Good

Is the service well-led?

Our findings

The service had an honest and open culture. The management described “leading by example” as paramount to achieving this. The senior care co-ordinator’s role included working directly with people to ensure that staff could observe practice and implement techniques in more complex cases. These were further discussed in meetings held specifically about the individual case as well as in general meetings to ensure good practice was maintained.

Quality control forms were sent to clients every 12 weeks requesting feedback on the level of support they received. Direct calls to people were made monthly to receive immediate feedback. The information correlated from these was used in supervisions, reviews of care packages, to further develop staff training, and as a mechanism for gaining an insight into the life of the person.

Monthly audits were carried out by the manager on training records, people’s reviews, supervisions, observations of staff practice and the staff handbook. The staff handbook contained concise policies for quick reference. The audit would illustrate where action needed to be taken. For example the training records system would notify the manager monthly of any training that required to be refreshed. Likewise if any policies required amending or updating, this would be noticed in the monthly handbook audit.

Quality assurance audits were completed annually by the management. Feedback was sought from commissioners, stakeholders, people, families and staff. The information was used to create an action plan. The action plan however did not always have written documentation on how tasks had been completed. The registered manager noted that it was important to evidence changes made as a result of the audit. We were advised that the next audit scheduled at the end of the year would detail this.

Complaint records were viewed during the course of the inspection. These illustrated transparency in investigation and reporting to the complainants. The new regulation on the "Duty of Candour" (Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014), was found to be followed. The investigations were completed within a suitable timeframe, with clear communication. In addition the service sent out redacted information of importance, updated policies, as well as monthly newsletters, to staff by post. This therefore meant that operational changes were quickly communicated to staff, and created an up to date and transparent working ethos.

Staff reported that the management were approachable with an open door policy. Staff were able to “drop in and have a quick chat” about anything that they wished to discuss. Further, by having management complete observations of their practice, as well as complete supervisions, staff felt this enabled continuity of standards.

We found there to be good management and leadership. The registered manager was supported by the senior care co-ordinator, in delivery and practice. She discussed any issues of pertinence with the nominated individual that required further guidance and organisational cohesion.