Culture Care Agency 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

Summary of findings

Overall summary

Culture Care Agency Limited provides a domiciliary care service to people in their own homes across five London boroughs. At the time of our inspection there were 26 people using the service.

At the last inspection, the service was rated Good. During this inspection we found the service remained Good. The service remained good because the appropriate care was carried out by staff and the management team who had the skills and knowledge to ensure people received safe care.

Staff had received sufficient training and were supported with their ongoing learning and development needs. Pre-employment checks were completed to assess the suitability of the staff employed and they understood the actions they should take to protect people from abuse.

Healthcare services were accessed by people and their medicines were managed safely. They were supported with the food they required and helped by kind and caring staff that respected their wishes. Personalised care was provided to people that suited their lifestyle and their cultural and spiritual needs. People's consent was sought before care was carried out and their decisions about this were adhered to. Call times were monitored to check that staff arrived and left their care visits so that people were safely supported with their care at the right time.

People felt they could approach the management team when they had concerns and were confident in their ability to resolve these. The provider sent people information to keep them informed of matters in relation to their safety and welfare, and regular feedback was sought from people to seek their views about the care they received. Checks were carried out in people's homes to make certain staff were following the correct procedures and ensure the delivery of good standards of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remains Good.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

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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 30 June 2017. The inspection was announced and was carried out by one inspector. We gave the provider five days' notice to ensure the staff we needed to speak with were available.

Before the inspection we checked information that the Care Quality Commission (CQC) held about the service including their previous inspection report and notifications sent to CQC by the provider. The notifications provide us with information about key changes to the service and any significant concerns reported by the provider.

During the inspection we reviewed five people's care and medicines records, three staff recruitment and training files, minutes of meetings, audits, surveys and some of the records relating to the management of the service. We spoke with the care coordinator and the registered manager.

After the inspection we contacted people by telephone and spoke with five of them. We also phoned 12 care workers and managed to speak with four of them. Additionally we liaised with a representative of a local authority to obtain feedback about how the provider delivered their service to people.

Good

Our findings

People told us they felt safe. They commented, "I feel safe, they shower and dress me, I have nothing to complain about" and "Very safe, I'm not scared with the carers and I am not scared to speak to them."

Staff had received safeguarding training on how to protect people from abuse and knew the importance of reporting work place concerns. Training records showed that staff were asked questions on how to recognise abuse and they had written the correct explanations of the different types of abuse and the reporting procedures. Staff we spoke with confirmed they applied this training in their work practice and knew what to do if they suspected people were at risk of harm. A member of staff commented, "Safeguarding is about making sure [the person] is safe in and out of the home, if there are any problems I report it straight to the manager." The registered manager was aware of their responsibility to report safeguarding concerns to the Care Quality Commission (CQC) and the records that we checked showed this was acted on.

Where risks to people's health and safety and welfare had been identified, appropriate management plans were developed to reduce the likelihood of risk. Risk assessments were carried out to address environmental issues, and areas such as falls, nutrition, infection control and personal care and these were kept under review. When risks had been identified we found that the appropriate action was taken, for example, the provider had contacted the community equipment service when it was noted a person's mobility equipment was not working. For another person, their call times were increased when it was found they needed support with the management of their medicines. However we found some inconsistencies in two of the risk assessments and noted these required more written guidance. The registered manager agreed to update these records.

Recruitment checks were carried out by the provider to assess the suitability of staff for the roles. We observed that when a potential employee arrived at the office the care coordinator spoke with them about their level of experience and the provider's registration process. The staff files we looked at showed that two suitable references were in place and any employment gaps had been explored. Right to work and criminal record checks were undertaken on staff before they began work.

Rotas showed there was enough staff to meet people's needs and the people we spoke with confirmed this. One person said, "I have a phone in place, [staff] clock in and clock out, I enjoy their company, they arrive on time and leave on time." Another person explained that if staff were running late the provider would inform them of this. In the event staff were unavailable to attend their care calls these were covered by the staff who

worked in the office. Systems were in place to monitor that staff had arrived and left their call visits on time. For one placing authority the provider used electronic call monitoring (ECM). Records demonstrated that the provider had scored a high compliance rate over the previous two months showing that staff were using ECM which meant the provider could monitor the actual times people received their care calls.

Information about people's medicines was documented in their care records and on the medicine administration records (MARs). Where people did not require staff to support them with their medicines care plans showed how they managed their medicines independently and contained clear guidance for staff to follow. Some people used prescribed ointments and creams. For one person we found that the topical administration record (TMAR) showed the names of the ointments and the accompanying body map highlighted where the topical medicines should be applied.

Good

Our findings

Staff had the skills and knowledge to provide people with care that met their needs. Staff explained they had completed an induction that required them to shadow more experienced members of staff to demonstrate how best to support people with the care that they required. Records showed a training programme was facilitated by the management team who had the assessed skills to teach staff in areas such as dementia, moving and handling, medicines, equality and diversity and safeguarding. The records we checked showed that staff had received this training and the staff we spoke with confirmed this. Evaluations of staff performance were carried out by the management team and feedback was provided to staff during their one to ones, group supervisions and annual appraisals.

People were supported to maintain sufficient nutrition and hydration. Care records described the food people preferred to eat and what they disliked and that staff should encourage people to cook and eat healthy meals. Some people required support with the preparation of their meals and others were able to make and store their own foods. One person told us, "I prepare my own breakfast, [staff] just need to heat some milk and pour it over the cereal, this morning I had porridge." Written notes gave staff clear guidelines to show them how people should be helped during their mealtimes. For one person, they provided information on where they stored their favourite food item, and for another, the preferred name they used for their choice of drink so staff could identify what the drink was and help the person to prepare this.

People told us about the decisions and choices they made about their daily routines. One person said, "The carers don't have to ask me what I need to wear, because I put everything out when I get up, and sort out what I want to wear."

Staff had an understanding of the Mental Capacity Act (2005) and were able tell us about people's capacity to make day to day decisions about their care and support. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

Care notes evidenced that a balanced view had been made about people's understanding of the information they received. Notes highlighted if people understood the care contract presented to them and highlighted if people could not sign their care records and the reasons for this. People's consent was sought,

for example, in relation to their medicines and sharing information with third parties involved in their care and support when this was appropriate.

People had access to healthcare services and their health needs were regularly reviewed. Details of health practitioners involved with people's care were written in their care plans and provided guidance for staff to follow if they observed any changes to their needs. Records held clear information of when people had been admitted and discharged from hospital and the reason(s) for this. This was included in the review of people's care and support needs, to ensure that staff provided effective care so they could be responsive to their health needs. Where people accessed health care services independently and were able to manage tasks without the help of staff this was documented, for example, with their oral healthcare.

Good

Our findings

People told us they were supported by kind and caring staff. They commented, "The carers come and turn me, so far the carers that have arrived have been very nice" and "They are kind, there is no fuss, I like them, we talk to each other and they do my washing up for me before they leave."

Care plans noted what was most important to people in their lives, such as their relatives, significant others and the external agencies involved with their care, for example, personal assistants. People's long term goals were recorded to show how the provider was supporting them to maintain their independence. Their objectives were written in their care plans, for example, to support them after a hospital discharge to help with rehabilitation and to maintain their nutrition and well being and the people we spoke with told us this was acted on.

Daily log books that were kept in people's homes were completed to demonstrate that people received person centred care. These were detailed and showed how staff accessed the home by knocking on the door and calling their name or by the use of a keysafe. They also noted where the person was when the staff member entered their home, for example, in the kitchen or the bedroom and when they exchanged greetings and pleasantries. Specific details were written that centred on the caring approach staff took, to help people with their personal care to ensure this was handled sensitively.

The provider had received written compliments from people to thank staff for good care they had received. We noted comments such as, 'staff are tender and gentle and good at folding clothes' and 'a job well done'.

People chose how they would like their care to be delivered and their decisions about this were respected. One person, had been sent an appointment letter by the provider to review their care package, as this time wasn't convenient for the person the provider had given them an alternative date of their choosing. Before new staff began working with people, the care coordinator accompanied them to people's homes to introduce them, build positive and trusting relationships and familiarise staff with how people wished to receive their care. A person commented, "[Care coordinator] brought the [staff] here and showed [them] what to do, as I need help to be guided in my home and in the community. They showed [staff] things like where to place their hands when I walk."

People told us their privacy and dignity was respected. One person commented, "Yes they do treat me with respect, I don't need to ask for much, some of them work really hard." Staff explained how they carried out personal care in a dignified way such as, drawing the curtains or blinds, closing the doors and asking

people's permission before they helped them to bathe.

Good

Our findings

People's needs were appropriately assessed and met. Care plans captured information based on the referral information sent from the local authority. This also included information from the provider's first assessment after they held one to one meetings with people and their representatives about their care. People's care records showed how they wanted to be supported in relation to their physical and mental health and their well being. Information comprised of written guidance to show if people required two to one care, if they requested same gender staff, and the details of multi-disciplinary teams involved with their care. Records noted people's hobbies and the activities they were fond of, in and outside of the home. One person told us, "I started water painting and jewellery making at [name of centre] the other week. It was [my relative's] birthday and thought I would surprise [them] with the jewellery. [They] were so surprised and loved it."

The provider had visited people regularly to review their care needs and to check the service was responsive to their changing needs. Communication records demonstrated the responsive action the provider took to make certain people received the appropriate equipment and aids during the reassessment of their care package. For one person, the district nurse had been contacted and visited the person to reassess their skin integrity and a pressure mattress was provided. The person we spoke with confirmed this was identified and actioned quickly by the care coordinator. For another person, the provider had written instructions for staff to follow to ensure the safe keeping of their keys. Following this a key safe was fitted in agreement with the person and their relative to ensure safe access to the person's home.

People were provided with a service that took into account their spiritual and cultural needs. They told us their cultural needs were met to ensure that the care they received was based on shared values and mutual understanding. Care records noted how people dressed according to their religious beliefs and the customs staff should follow when they arrived at people's homes, for example, covering their footwear. Following a person's discharge from the hospital, the provider noted they had not resumed their regular church service and had asked if the person required any further support with this but they declined. For another person, records showed they had expressed that their health care need be met in a way that adhered to their cultural and spiritual beliefs.

People told us they knew how to make a complaint and when they had raised concerns these had been resolved quickly. The provider had a system to manage complaints and the provider told us no complaints had been received for the previous year. Records showed during people's reviews they were reminded by the provider of the complaints policy and how to make a complaint and if they required this information in a

format that was easy to read to support their understanding.

Good

Our findings

People told us the service was well managed and commented, "The manager is very good, [they] come around and we have a talk if things aren't going right" and "It's well run, I have no arguments about that."

Staff told us they felt supported by a management team who would willingly assist them when this was needed. They commented, "They tell me every time, if I am unsure of anything I have to ask them for help" and "They are good and have good rules, if I don't understand anything they will always explain."

Letters sent to people showed that the registered manager acted on public information of concern to protect their welfare and safety. In relation to a widely publicised incident that had occurred, the provider had written to people to advise them to check on their fire safety arrangements and evacuation plans in their home and to contact the office if they required further assistance with this. Information about public health was sent to people called 'beat the heat' which signposted them to guidance about staying cool and keeping hydrated during the periods of warm weather. This demonstrated that the provider kept up to date with information on public health, as lessons learned and used them as prevention measures to mitigate risks to people's safety and well being.

The registered manager explained they kept a check on the support tasks that staff provided in people's homes in order to manage people's expectations and to pre-empt any concerns. They commented, "We have to be proactive in the monitoring of the service. Some staff go above and beyond of what the care packages ask of them, we have to remind them to adhere to the care plans."

Audits were carried out during spot checks on people's safety, their care records and included observations on staff skills and practice. A person commented, "[Care coordinator] came around and checked the books, every three months they check everything is alright." During a spot check records showed that the provider had identified that suitable equipment was required to support the person with their healthcare needs, and spoke with the occupational therapist who supplied this. Team meetings were held to discuss staff responsibilities in relation to audits and their designated duties.

The provider sought feedback from people about how the service could be improved during their annual reviews. People were asked if their call times were suitable, if they required more or less support or if they would like their call times to remain the same.

Surveys had been sent to people to check their satisfaction with the service and to find out what the

provider could do better. These showed that 75% of people were satisfied with the quality of the service. However, surveys required further scrutiny to evaluate the feedback that showed 25% of people were 'nearly satisfied' with the service. This would identify if further improvements were needed to the way the provider delivered care.

A local authority that made referrals to the service had conducted quality checks to assess the standards of care and the provider was working to address any shortfalls they found. The provider was aware of the requirement to notify the CQC of important events affecting people using the service. We had been promptly notified of these events when they occurred.