Care Line Homecare Limited

Careline Homecare (Hartlepool)

Inspection report

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Date of inspection visit:
05 October 2015
06 October 2015
09 October 2015
19 October 2015

Date of publication:
18 January 2016

Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

The inspection took place on 5, 6, 9 and 19 October 2015. This was an announced inspection. At the last inspection in January 2014 we asked the provider to take action to make improvements in maintaining accurate records about people's care and treatment. At this inspection we found the provider had made progress and these improvements had been made.

Careline Homecare (Hartlepool) is a domiciliary care service which provides support with personal care, domestic tasks and shopping to people living in their own homes. At the time of this inspection 275 people were using the service.

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.

We found the provider had breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider did not have accurate records to support and evidence the safe administration of medicines. We found that prescribed creams and ointments were not being recorded as administered so it was unknown if this had taken place in the right way or at the right frequency.

You can see what action we told the provider to take at the back of the full version of the report.

People using the service told us they felt safe when regular staff supported them. Some people had regular teams of care staff. This made them feel confident in the staff who supported them. Other people said they did not know which care staff would visit them and were not always told if they were going to be late. People and staff told us care staff were not allocated travelling time between calls. This meant people who used the service did not always get their full visit.

Staff completed safeguarding adults training as part of their induction and had annual refresher training. Staff knew how to report concerns and were able to describe various types of abuse. Staff we spoke with said if they had any concerns they would raise them immediately. This meant they knew how to deal with any concerns about people's safety.

There were enough staff employed to carry out most of the visits that were required, and the agency constantly recruited new staff. The agency made sure that thorough background checks were carried out before staff started to work with people who use the service.

Risks to people's safety and health were assessed, managed and reviewed. Accidents and incidents were recorded and dealt with effectively by the provider. Where issues had occurred, actions had been taken and

lessons learnt.

People and relatives felt their regular staff knew what they were doing and were competent in carrying out their role. People who did not receive regular care workers were less satisfied with the service. For example, some people felt they had new staff too often.

Staff told us they received appropriate training and opportunities to shadow established care staff before doing calls on their own. Staff received regular supervisions, spot checks and appraisals. These were used to identify future training and development needs for each staff member, so that staff were supported with their professional development.

The registered manager understood the requirements of the Mental Capacity Act 2005 (MCA), and told us no one was subject to a court of protection order. Staff received training in MCA and understood how to encourage people who used the service to make choices where they had capacity to do so. Staff knew how to seek appropriate support for people should they lack capacity in the future.

Each person who used the service had an assessment about their nutritional well-being. Where people had needs in this area they were supported with nutrition and making meals as part of their individual care package. Care plans were personalised and included details of people's preferred way of being supported.

People were positive about the caring nature of the staff. People and their relatives described care staff as lovely, kind and like part of the family. People said their dignity and privacy were respected and maintained by care staff.

People had their needs assessed when they started using the service. This included gathering information about the person to help staff better understand the people they cared for. This information was used to develop personalised care plans so staff could support people in a way that was appropriate to their individual needs. People kept a copy of their care plans in their own homes so they and their care staff could refer to them at any time.

People knew how to complain if they were unhappy and said they would feel comfortable doing so. People were frequently asked for their views about the service and any issues were acted upon. Feedback from the most recent consultation had been positive.

The service had a registered manager. Staff told us there was a good ethos at the agency and they felt supported by their managers.

The provider carried out annual quality audits which included areas such as safety and security of the office, staffing and the quality of the service. The audit identified some areas for improvement. An action plan listed the shortfalls and deadlines for completion, although there was no evidence that these matters had been addressed or reviewed.

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.

This was because prescribed creams and ointments were not being recorded as administered so it was unknown if this had taken place in the right way.

People using the service had mixed views about whether they felt safe. Some people told us they felt safe when regular staff supported them, but those who had a varied staff team felt less safe.

Staff had a good understanding of safeguarding adults and whistle blowing.

There were recruitment and selection procedures to check new staff were suitable to care for and support vulnerable adults.

Is the service effective?

Good

The service was effective.

The registered provider had developed a structured induction programme for new staff. Staff received training to help them care for people appropriately.

Staff received regular supervisions and appraisals.

People were supported to meet their nutritional needs. They were also supported to access other healthcare services when required.

Managers and staff were aware of the Mental Capacity Act 2005 and how to apply this to people in their care.

Is the service caring?

Good

The service was caring.

People said staff were kind, caring and respectful.

People were supported to be as independent as possible whilst

retaining their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

There had been improvements to care records. These contained a good level of detail and were personalised about each person's needs and preferences.

When people's needs changed this was discussed and care plans were updated to reflect this.

People were given clear information about how to make a complaint.

Complaints were recorded and acted upon.

Is the service well-led?

Good

The service was well-led.

People knew who to contact within the agency if they needed to. People were regularly asked for their views about the service.

The agency had a registered manager who was supported by a senior management team.

The provider had a quality assurance system to check the safety and quality of the service.

Careline Homecare (Hartlepool)

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 5, 6, 9 and 19 October 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience supported the inspection by telephoning people in their own home to gather their experiences of care and support being provided.

We reviewed other information we held about the home, including the notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also contacted the local authority commissioners for the service, the local Healthwatch and the clinical commissioning group (CCG). We did not receive any information of concern from these organisations.

We spoke with 28 people who used the service and four family members. We also spoke with the registered manager, the area manager, a senior co-ordinator, a trainer, a co-ordinator, a supervisor and four members of care staff. We looked at a range of care records which included the care records for 12 people who used the service, medication records for 12 people, recruitment records for 10 staff, and other documents related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed in the right way. The provider used locally agreed medicines procedures, which were required as part of its contractual arrangement with commissioners from the local authority. The registered manager told us their procedures were in line with the 'model of good practice for the development of policy for the safe handling, management and administration of medication by carers within domiciliary care across the North East of England'. This document was over six years old and there was no indication when this was due to be reviewed.

Where people needed support with medicines, the agency recorded the assessed level of assistance they required. For example, whether someone needed a verbal reminder to take their medicines (level one), or physical assistance only (level two), or whether they needed full support to take their medicines (level three).

However the administration of topical medicines was not being managed or monitored in a safe way. The agency did record on medicines administration records (MAR) when they had supported people who needed level two support with prescribed creams and ointments. This meant there was no clear audit trail of creams and ointments that had been administered during each visit, to ensure this was done in line with administration instructions.

This was contrary to the model of good practice the registered manager told us they followed. This was because the document stated that creams or ointments must be covered by the completion of a MAR. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A person who used the service told us, "I get on really well with my regular carers, particularly in the morning when I need help with my bath. They make me feel really safe and supported."

Staff told us that people who use the service were safe. One member of staff told us, "It's our job to keep people safe."

Risks to people's safety and health were appropriately assessed, managed and reviewed. Supervisors who were trained in assessing risk had carried out and recorded risk assessments before the agency provided the care service. These included an assessment of the safety of the person's home and equipment, and any potential risks relating to falls, mobility, medicines, skin care and nutrition. The risk assessments were regularly checked to make sure they were still relevant. Any accidents or incidents that occurred during the delivery of care were reported by care workers to the office staff so that these could be logged on the agency's computer system. In this way these events could be checked for any trends.

Staff had a good understanding of safeguarding adults and their role in preventing potential abuse. Staff told us, and records confirmed, they had completed training in safeguarding vulnerable adults as part of their induction training and then annually. Staff knew how to report concerns and were able to describe various types of abuse. Staff we spoke with said if they had any concerns they would raise them

immediately.

A safeguarding file which contained up to date policies and a list of relevant contacts if an issue arose, was available in the office. A safeguarding log was kept which showed the registered manager had taken appropriate action. In the case of one safeguarding incident the service had worked closely with local police and social workers, which meant the service worked in partnership with other agencies to protect people from harm. The service had also taken appropriate disciplinary action where necessary.

Staff had also received information about their duty to report any poor practices of other staff, which is called whistle blowing. Staff we spoke with confirmed they were fully aware of their responsibilities to protect people in this way. One staff member told us, "If I had any concerns I would report them straight away to my manager or the registered manager without hesitation".

There were thorough recruitment and selection procedures in place to check new staff were suitable to care for and support vulnerable adults. We found the provider had requested and received references, including one from their most recent employment. Eligibility checks had been carried out and proof of identification had been provided. A disclosure and barring service (DBS) check had also been carried out before staff started work. These checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

The people and relatives we spoke with felt there were enough staff employed to carry out visits, although for some people there was no consistency in the staff who attended to them. Some people were concerned about the number of new care workers who turned up without any prior introductions or notice from the agency. People who did not have regular care staff said this created difficulties in having to explain what they should do. Their comments included, "I don't always get the same carers. It's very welcome when carers come that are familiar and know the set up", "The staff are different every time" and "I wish my regular carers could come all of the time because I do feel frustrated when I get somebody who I haven't even met before. I'm 95 and I really don't feel like having to tell someone new every day what I need."

The registered manager told us they knew having consistent staff was an issue for some people who used the service, so they were in the process of recruiting more staff to address this.

People who did not receive regular care workers felt that new staff had to be shown how to do basic tasks like making a bed or peeling a potato. One person told us, "The carers who have been coming for a long while know what they are doing. However I am fed up of getting new carers who struggle with even the basics."

Care co-ordinators and care workers said there were enough staff employed to provide the service but it was difficult to provide consistency if several staff were on sick leave or holiday at the same time. The operations manager told us the agency constantly recruited new staff. Care co-ordinators told us that care workers were "flexible" when asked to cover visits for other staff, often at short notice.

Some people told us that care staff were often late to start their visits but understood that staff had to travel from one visit to another. One person told us, "I can't rely on them time wise. Sometimes they're early for lunch and late for tea. I get on with the carers alright but it is a bit much when you're waiting for your tea. I worry about not getting my tea."

The registered manager told us call times are logged in records kept in people's homes. Care staff are expected to contact the office if they are running more than 15 minutes late. The registered manager told us

people who used the service are advised to contact the office if staff have not turned up after 15 minutes of their planned call.

People who used the service were concerned about the lack of time given to care staff for travelling between visits, as this sometimes meant visits were rushed or cut short. One person we spoke with said, "They don't allow the girls time to travel in between calls. Sometimes the carers can't get out quick enough."

A staff member we spoke with said, "If people have a 30 minute call they should receive care for 30 minutes. Carers need that time to communicate as this is the best form of rehabilitation. People need to have a chat."

People had mixed views about whether the agency kept them informed if staff needed to change at short notice so they knew who would be visiting to provide their care. One person told us, "It doesn't happen often but sometimes I get different carers to those on my sheet." Another person told us, "The last few weeks I haven't known who was coming." People had mixed views about whether the agency informed them if care staff were going to be late. Their comments included, "They don't ring me to let me know if carers are going to be late" and "They usually ring if they're going to be more than 15 minutes late". Care co-ordinators told us it was not always possible to inform people if there was going to be a change of care worker or if they were going to be late.

The registered manager told us people who used the service are given rotas on a weekly basis, so they know which care staff to expect. They said they try to cover calls with staff already known to a person who used the service during periods of staff sickness. The registered manger told us co-ordinators aimed to contact people who used the service to notify them of changes but acknowledged this had not always been possible. The registered manager told us they had increased the number of co-ordinators working in the office so people who used the service could be kept informed of changes to their calls.

Good

Is the service effective?

Our findings

People and relatives felt that regular staff who had been with them for some time knew what they were doing and were competent in carrying out their role. For example one person we spoke with said, "Yes I think my carers have had enough training". Another person told us, "The carers are trained and they know what they're doing."

Staff told us they received appropriate training and opportunities to shadow established care staff before doing calls on their own. One staff member told us, "I had a lot of training before I started. I learned a lot during induction. The training was practical and really good." Another staff member said, "Yes I've got the right skills to help people."

We spoke with the training facilitator who told us, "Staff are adequately trained and their skills are continually refreshed." They also said, "I get satisfaction from my job as I know I'm giving people the skills to do their job and helping them to demonstrate empathy and respect for the people we care for."

Staff told us, and records confirmed they received training in areas such as diabetes care, health and safety, food hygiene, infection control, emergency aid, medicines, moving and assisting, and nutrition. New staff completed a comprehensive induction course that included mandatory training in principles of care and health and safety before they could start working at the service. The agency employed a training facilitator and had a training room at its branch office. This meant staff could complete practical, classroom based training on site. Training records we viewed confirmed staff received regular training. The provider had a computer based system in place to ensure training was kept up to date.

Staff told us they felt supported. One staff member we spoke with said, "There's a friendly approach so I'm not afraid to raise things. I had an accident recently and the manager and staff were really kind."

Records we viewed confirmed staff received regular supervisions, spot checks and appraisals. We saw these were used to identify future training and development needs for each staff member. For example, future training needs included equal opportunities, healthy eating and palliative care. This meant staff were supported with their professional development.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us no one currently using the service was subject to any restriction of their freedom under the Court of Protection, in

line with MCA legislation.

Staff told us most people they supported had capacity to make their own decisions, although they did support some people living with the early stages of dementia. Staff received training in MCA and understood the concept of ensuring people were encouraged to make choices where they had capacity to do so. Staff told us if there was a doubt over someone's capacity they would discuss the matter with the person's family, contact the mental health team and contact social services. This meant staff knew how to seek appropriate support for people should they lack capacity in the future. There was an up to date MCA policy at the service.

Each person who used the service had an assessment about their nutritional well-being. Where people had needs in this area they were supported with nutrition and making meals as part of their individual care package. The care plans about this were personalised and included details of people's preferred way of being supported. For example, one person's nutritional care plan stated, "I would like the carer to help me prepare something light for lunch. Please make sure I have plenty to drink. I will tell you when I am full."

Care workers completed detailed daily notes which recorded what meals they had prepared and how much people had eaten. This helped supervisors check whether people needed increased support in this area.

One person who used the service told us, ""My carer is always reminding me to drink more than I do. I know it's better for me if I drink plenty of water so I am really grateful that she is there to encourage me."

Staff said they asked for consent before delivering care. They said they would respect the person's decision, including their right to refuse, but they would explore the reasons with the individual concerned. A person who used the service told us, "My carer always asks me if I'm ready to make a start in the morning. I appreciate that she thinks about me and wants to make sure that I'm okay before we start our activities for the day."

Staff made appropriate contact with healthcare professionals when the need arose to seek further advice or guidance. The registered manager told us, "The main agency we work with is social services, and we go to the social workers' team meetings. We also have a good relationship with the local authority and the district nurses."

Good

Is the service caring?

Our findings

People and family members said they received good care. One person we spoke with said, "Staff are kind, you can't fault them. They do more than they're supposed to do, they bend over backwards. I get on well with all of them." Another person commented, ""Staff listen to me and understand what I need. I really can't fault them." Another person said, "I like the staff, they are kind and caring."

People told us staff showed concern for their wellbeing in a caring and meaningful way. One person told us, "I wasn't feeling very well last week and my carer insisted on going and fetching me a tin of soup which she made for me before she left." Another commented, "My main carers are lovely. I haven't been very well lately as I had a bad cold and my carer said that she would pop back later in the day to make sure that I was alright. She went out of her way to make time to pop in and make me a hot drink and make sure that I had something to eat that day. I really appreciated her kindness." Another said, "The carers are very patient with me and I am really grateful for that."

We asked people whether staff treated them with respect. One person replied, "The staff take great pains to maintain my privacy and dignity when bathing me. It's better than I would have expected." One family member said, "Staff are very respectful and preserve [my relative's] dignity."

Staff had a good understanding of the importance of treating people with dignity and respect. Staff described to us how they ensured people were respected by being discreet, keeping people covered when doing personal care and explaining to them what was happening.

We asked people if they can be as independent as they want. A person who used the service told us, "My carer makes sure I do as much as I can for myself. I feel safer when she is with me because I have a tendency to fall over if I'm not careful. I don't like having to ask people to do things for me so I do appreciate the support she gives me to still try and do things for myself."

We asked staff how they promote independence, dignity and respect. One staff member told us, "As a service we give people dignity, support and promote independence as much as we can. Dignity is a big thing for me as people who use the service deserve dignity. Independence is important because we know that most people want to stay in their homes as long as possible." Another staff member said, "I try and encourage people to be as independent as possible. I do shopping calls with people and help them to go to the shops that they want."

We asked people how they are assured that information about them is treated confidentially and respected by staff. One person who used the service said that they were assured of this because if care staff are running late "they never say what's happened as they are professional and keep things confidential."

Good

Is the service responsive?

Our findings

At the last inspection of this service in January 2014, we found the provider had not met a requirement relating to records. This was because, at that time, records were incomplete or did not reflect the needs of some people. Since the last inspection the provider had introduced new care records. This had improved the quality of recording including details about people's individual needs. We found the service was now meeting the requirements of the regulations relating to records.

Each person's needs were assessed and set out in a care plan before their care package was put in place. The care plans included clear guidance for staff about how to support people with their needs, such as mobility, personal care and medicines. People kept a copy of their care plans in their own homes so they and their care workers could refer to them at any time.

People had been fully included in their own care planning, where capabilities allowed, and had given their consent. The care plans were written from the perspective of the person and were titled, 'How I can be supported to achieve my goals'. Care plans were reviewed on an annual basis or more often if people's needs changed. In a survey sent out by the provider in May 2015 67% of people felt totally involved in the planning of their care.

We asked staff what they would do if a person's needs change. One staff member told us, "When a person's needs change I would inform the office so they could tell the social worker and tell the family. I always ask the person rather than make assumptions. I always check what the individual wants."

There were clear examples of the provider responding to and acting on people's changes in needs. For instance, care staff had noted a change to the condition of one person's skin. As a result a skin integrity risk assessment was carried out, a new care plan was put in place and staff now supported the person with creams to prevent any pressure damage.

Care was provided for people with a wide range of needs including people with physical disabilities, dementia, mental health needs and other disabilities. The care records were written in a sensitive way that promoted each person's individual support needs and their abilities. For example, one person's care plan included detailed explanation of the person's use of body language to communicate.

The care files also included personalised information about each person in a section titled, 'About me and my life'. This included detailed information about each person's preferences, life history, choices and spiritual beliefs. For example one person's life story stated, 'I am a very private person. I just like to talk about day to day things.'

People were provided with a comprehensive information pack about the provider and the standards they could expect. This was set out in a detailed service users' guide. The guide included clear details of how to make a complaint and contact details of other relevant agencies people could discuss their complaint with. At the time of our inspection this was not available in other formats such as easy read, but the registered

manager told us it was available on request.

Complaints were recorded on paper and also logged on the provider's business management tool. There were two recorded complaints in the past year. These were made by relatives in relation to communication from the agency when a care worker was late, and care staff not using a person's key when they had requested this. The complaints records included details of the outcome and actions taken by the registered manager to resolve the concerns. In a survey sent out by the provider in May 2015 89% of people said they would know how to complain and 77% said they would feel comfortable complaining.

Good

Is the service well-led?

Our findings

The provider had a registered manager who was also responsible for the day to day management of the care service. She was supported by a number of office based staff care including care co-ordinators and supervisors. There was a clear organisational structure that identified the provider's senior management arrangements and this was displayed in the office for staff.

People who used the service were provided with an information pack that included details of the organisation and its values.

People were frequently asked for their views about the service they received. Supervisors carried out three-monthly spot checks of staff practices and six monthly quality visits and asked for people's comments during those visits. People also received telephone checks of the service. These were recorded and any issues were acted upon. For example, one person had told the supervisor that they would prefer a different care worker. The staff rota was changed and the person was now satisfied with their new care worker.

Staff felt they received sufficient information about the provider's expectations and standards. These were set out in a staff handbook. Office staff commented they felt supported by their line managers and felt it was a good organisation to work for. For example, one care co-ordinator told us, "I feel very supported by my colleagues and by the manager." Staff felt the ethos and culture within the agency was "very good" and some staff had worked there for several years. One staff member told us, "I love it here and I love the job – I feel we provide good care for people and we're all committed to the service."

The staff we spoke with told us that staff team meetings were held regularly, usually every three months, where staff attended the local office. Staff told us the meetings were used to inform them of expected practices and they also felt able to contribute their comments at the meetings. The most recent meeting in September 2015 included discussions and instruction on skin integrity, confidentiality and service user involvement. All members of staff were also sent a monthly newsletter with any information or changes within the agency. The office staff we spoke with felt the only area for improvement was new office premises as the building was becoming unsafe and there was insufficient storage room for filing. There were plans for the agency to move offices in the near future.

The agency had a number of quality assurance checks to make sure the service was safe and effective for the people who used it. During 'spot checks' of individual members of staff, supervisors made sure they were carrying out their role and any support tasks in the right way, and the outcomes of the checks were recorded.

The 'home care report books' for each person (which included daily reports) were brought back to the office every two to three months. These records were checked by care co-ordinators as part of a care recording audit. Medicines records were brought to the office on a weekly basis and were also checked for any discrepancies. Where necessary this led to individual discussion with a care staff and any retraining or supervision was identified.

The provider had a computer-based management system to record any events that could be used to monitor the quality and safety of the service. These included, for example, complaints, accidents, missed calls, medication errors and staff training deadlines and supervisions. In this way the agency aimed to check for any gaps or areas for improvement in the service.

The provider carried out annual quality audits and the last one was done in December 2014. The quality check included several aspects of the branch including safety and security of the office, staffing and service delivery. The audit had identified some areas for improvement. For example, around storage in the office and staff records. An improvement action plan listed these shortfalls and deadlines for completion, although there was no evidence that these matters had been addressed or reviewed.

The agency was part of a national organisation. The area manager told us the organisation aimed to use its knowledge of group-wide trends to "develop initiatives of best practice and new ways of working to continuously improve the way we do things to meet the changing needs of our services." For example, accidents and incidents were analysed and acted upon.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe or unsuitable care and treatment because records and systems operated by the registered provider did not support the safe management of medicines. Regulation 12 (2) (g).