Cleeve Hill Health Care Limited

Cleeve Link Homecare

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?	Requires Improvement
Is the service well-led?	Good

Overall summary

This was an announced inspection which included a visit to the offices of Cleeve Link Homecare on the 12 and 16 February 2015. This was followed up with visits to people in their own homes on 13 and 16 February 2015. This service moved offices in August 2014 and this is the first inspection of the service at this location.

Cleeve Link Homecare provides personal care to people living in their own homes in areas around Cheltenham, Tewkesbury, Evesham, Kidderminster and Worcester. Live in 24 is also based at this location and provides full time live in care for people living in England. At the time of our inspection personal care was being provided to over 500 people.

There are two registered managers, one for Cleeve Link Homecare and another for Live in 24. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run. The registered managers were supported by another manager and senior supervisors.

The provider acknowledged the challenges facing them of delivering personal care to a large number of people across a large area. They had restructured the way the

Summary of findings

service was provided and staff were allocated to work in an area where a number of people used the service. This was providing greater consistency of care and improving the experience of people using the service and of staff. People commented, “for the last year things have been good”, “a lot better now” and “consistency is so important to me and they have it right”. Quality assurance processes involving feedback from people and staff were used to improve the service and people’s experience.

People raised concerns with us about getting through to the office when using the telephone, the impact of travelling time on people’s visits and understanding staff whose first language was not English. The provider was aware of these issues and had plans in place to improve telephone systems in the office and to tackle the problems of travelling times between visits. They assessed the competency of new staff to speak and write English as well as providing English lessons.

People were kept safe from potential harm and said having a consistent staff team helped them to feel safe. People were protected against hazards and the risk of accidents. Staff were provided with guidance about how to reduce risks to people and how to keep them safe. Staff knew how to keep people safe whether by providing appropriate personal care such as monitoring people’s skin condition to raising concerns about suspected abuse. People knew how to raise concerns. People’s view of the handling of their complaints varied according to their individual experience ranging from satisfied to frustrated with the response to their concerns.

People’s needs were assessed and their care plans provided an individualised account of how they wished to be supported. There were inconsistencies in the quality of records kept in people’s homes. People’s background, routines and preferences were reflected in the delivery of their care and support. There were sufficient staff to meet people’s needs. Arrangements were made to cover in an emergency and support for staff out of normal working hours. Staff were supported to develop in their roles and had access to a range of training. Robust recruitment and selection procedures were followed before staff were appointed.

People were treated respectfully and with kindness. They were asked for their consent before personal care was provided. They were offered choices and discussed with staff how they wished to be supported and cared for. People’s health and wellbeing was monitored and any changes were reported to managers or to health care professionals.

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?

Good

The service was safe. People were safeguarded from possible harm. Staff recognised the signs of abuse and would raise concerns.

Risks were managed effectively keeping people safe from possible harm.

There were sufficient staff with the right skills, knowledge and experience to meet people's needs.

Medicines were administered safely. Infection control procedures were followed by staff to protect people from acquiring infections.

Is the service effective?

Good

The service was effective. People received support from staff who had the skills and knowledge to meet their needs. Staff had access to training and support to help them to develop in their roles.

Staff were aware of the Mental Capacity Act 2005 and its application, supporting people to make decisions and choices about their care.

People were supported to eat and drink where needed. Their health and well-being was monitored and staff contacted healthcare services when needed.

Is the service caring?

Good

The service was caring. People were treated kindly, courteously and given reassurance. Staff understood how people preferred to be supported and cared for.

People were involved in reviews of the care and planning how they would like their care to be delivered.

People were treated with dignity and respect. Their independence was encouraged.

Is the service responsive?

Requires Improvement

The service was mostly responsive. People received care which was individualised and matched how they wished to be supported. Although changes in people's care were responded to quickly, some care records did not reflect the care being provided.

People's experience of how their complaints were dealt with varied. Learning from complaints was used to improve the service provided.

Summary of findings

Is the service well-led?

Good

The service was well-led. People, their relatives and staff provided feedback about their experience of the service. In response improvements were made. The vision and values of the service were understood and upheld by staff.

People and staff found the managers open and accessible. Staff were supported to carry out their duties and understood their roles and responsibilities.

The challenges of providing and managing a large service were taken on board and improvements made to improve the quality of service delivered. Through involvement with local organisations, managers and staff kept up to date with current best practice. Action was taken in response to complaints, accidents and incidents to learn from these and prevent them happening again.

Cleeve Link Homecare

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 12 and 16 February 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 they would be available.

This inspection was carried out by two 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 care service. The expert's area of expertise was caring for older people. Prior to the inspection we looked at information we had about the service including notifications and feedback from the local authority commissioning team. Services tell us about important events relating to the service they provide using a notification. Before the inspection, the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of this inspection we visited 10 people in their homes. We spoke with them and their relatives as well as the staff supporting them. We had telephone discussions with seven people who use the service and 11 relatives. We talked with the registered managers, senior management, six staff based in the office and five staff supporting people in their homes. Prior to the inspection we had feedback from Healthwatch and local commissioners of services. After the inspection we had feedback from social and health care professionals. We reviewed the care records for 10 people using the service, five staff files, quality assurance audits and policies and procedures.

Good

Is the service safe?

Our findings

People told us they felt safe having the staff in their homes to provide their care. People said, "You just accept that strangers come into your home, it helps to have the same carers", "I feel safer because they have supported me for so long" and "I always felt safe". Another person told us staff left them comfortable and safe with their communication aid and lifeline in place. People knew how to raise concerns if they had any. They had been given information about who they could contact in an emergency or out of normal working hours. Those who had used this system said it worked.

Staff supporting people had completed training in the safeguarding of adults. Staff discussed with us their responsibilities in raising concerns about suspected abuse and the records they needed to keep. Staff were confident managers would take action in response to their concerns. They said they would record any bruising or marks. They would inform managers at the office if these were unexplained. If there had been an accident or incident they would record this and alert the office so they could take any necessary action such as making referrals to health professionals.

Where safeguarding concerns had been raised in relation to allegations of abuse or harm, the registered managers had taken the appropriate action. They had contacted relevant agencies and forwarded notifications to the Care Quality Commission. Services tell us about important events relating to the service they provide using a notification. Action had been taken to make sure people were safe and protected from further abuse. If staff were involved, they had been suspended and disciplinary action had been taken when necessary.

Risks to people and staff were assessed before service commenced. These included making sure the environment was safe. One registered manager described how they had worked with a person and their relative to make sure all the necessary equipment and facilities were in place before they returned back to their home. The provider carried out periodic checks in people's homes to make sure equipment and the environment were being maintained safely. Staff completed health and safety training and said any concerns would be reported immediately to the person using the service and to managers.

Any hazards people faced had been assessed and risk assessments described how these had been minimised to keep people safe. For example, where people needed help with moving and handling a range of equipment such as hoists or sliding sheets had been provided. Records identified what people could do for themselves and the help or support they needed from staff to reduce any risks they faced. People had been involved in decisions about how risks were managed. Staff talked through any actions they were taking to keep people safe and involved people in making choices about how their care was delivered.

Some people were at risk of developing pressure ulcers and their care records highlighted this risk. Strategies were in place to prevent skin deterioration and staff knew people's skin condition had to be checked daily. Relatives said staff were good at noticing any changes in people's skin integrity and told them straight away. Any concerns would be recorded and managers informed. A registered manager confirmed they monitored these records to look for any changes in people's needs which required a referral to health care professionals.

People's needs were assessed prior to the service starting to determine the number of staff they needed to provide their care and support. Some people were allocated two staff for part or all of their visits. They told us they always had two staff to carry out their care. The length and times of visits were agreed with people or their funding authority if appropriate. Staff reported where there were concerns that the level of care could not be carried out in the time allocated or where people's needs had changed. There was evidence visits or the length of visits had been increased to accommodate people's needs.

People expressed mixed views about the timing of their visits. Occasionally staff were late arriving or there was little consistency in the timing of their visits. One person told us, "Time-keeping is variable - sometimes they can arrive early, sometimes late." Another person said, "Sometimes they're a bit late - if there's a problem with another client, they can't just drop it, but I don't mind. I made one girl late the other week - I tripped up and the carer had to wait for the paramedics with me. She rang the office to tell them." However this was not everyone's experience. People commented, "carers are well on time" and "mostly satisfied, the odd one rushes but this is the exception to the rule".

Good

Is the service safe?

The provider had reviewed and restructured the way staff were assigned to people. Wherever possible they had co-ordinated staff to work in localities reducing the amount of travel time between visits to make sure staff were in the right place at the right time. Staff said this was working really well and people commented they had a more consistent staff group attending to their needs. An electronic system logged the start and finish times of visits so managers could monitor the length of visits. This would eventually alert the managers to missed visits. Standby staff were employed to cover for last minute emergencies. Staff told us managers would also help if needed. A member of staff said, "There was always someone at the end of the telephone night or day."

People were supplied with information about how staff were recruited and the checks which were in place to ensure their competency and fitness. The recruitment and selection process assessed whether new staff had the character and experience to support people. Comprehensive checks were completed before staff started work which verified a full employment history, any relevant training and obtained feedback from previous employers. A Disclosure and Barring Service (DBS) check was received. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with vulnerable people. There was proof the identity of new staff had been checked and whether they needed to have a work permit.

Some people needed help with their medicines. People had given their consent for staff to administer their medicines. Their care records clearly stated what level of support they required whether this was just a reminder or staff giving them their medicines. Medicine administration charts were used to record when medicines had been given by staff. Staff gave people their medicines when they wanted them and with drinks if that is what they wished. Staff confirmed they had completed training in the safe handling of medicines. They were periodically re-assessed to make sure they were competent. A person told us they were impressed when staff supporting them found an error with their medicines provided by a pharmacy.

People were protected against the risks of cross infection. Staff had completed training in infection control. They had supplies of personal protective equipment such as gloves and aprons. They washed their hands as soon as they arrived in the person's home. Gloves were worn when delivering personal care and changed when preparing food. Gloves were changed and disposed of appropriately in double bags, in line with the provider's guidance. The provider had an infection control lead and an up to date infection control policy and procedure. An annual statement would be produced in line with the Department of Health's code of practice on the prevention and control of infections.

Good

Is the service effective?

Our findings

One person told us, “Consistency is so important to me, and they have it right.” People commented that the continuity of care had improved and most people had the same staff supporting them. People said, “The vast majority of the time, the girls that come here do a good job” and “The girls are a credit to their manager”.

The provider information return stated there had been a significant staff turnover in the last 12 months. New staff confirmed they had completed an induction programme and shadowed existing staff before being allowed to work alone. Their practice was also observed for example carrying out moving and handling tasks or administering medicines. People told us new staff usually worked with existing staff until they had learnt their routines. Although one person said they had several new staff due to the high turnover which meant staff needed prompting about their routines. They said this had settled down recently. The provider had recognised these issues and changes to the allocation of staff had improved consistency of care.

People confirmed most staff had access to training specific to their individual needs. Staff said they had completed training in tissue viability, peg feeding, catheter care, dementia awareness and end of life care. This was in addition to training considered mandatory by the provider such as safeguarding and moving and handling. The training needs of staff were monitored and records highlighted when refresher training was needed. Staff were observed carrying out personal care and other tasks by senior staff. Where issues were identified these were addressed through individual meetings with their manager or by completing additional training. Staff said they were supported to register for the diploma in health and social care and management qualifications.

People commented about problems communicating with staff whose first language was not English. New staff were assessed for their competency in written and verbal English. Coaching in English was provided for staff. Staff we observed communicated effectively and were understood by the people they supported. Every now and again people would ask for staff changes to their team if they felt they had not been matched successfully. Managers would arrange alternative cover.

Staff had individual meetings with senior supervisors or their managers. This gave them the opportunity to discuss their roles and responsibilities and to monitor their training needs. Staff said communication was good with staff in the office and they felt supported in their work. Managers said welfare officers had been appointed to support staff with private or work matters. They said this had been welcomed by new staff. Team meetings were held which included discussions about changes to the service and monitoring people’s assessments and care records.

Staff had completed training on the Mental Capacity Act 2005 (MCA) and understood the need to assess people’s capacity to make decisions. The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. People had been asked if they gave their consent for their care and support to be provided in line with their care plans. People or their legal representatives had signed these forms. Where a person had a legal power of attorney for welfare they had been asked to supply evidence of this. Staff sought people’s permission before helping them with their personal care or supporting them to take their medicines.

Occasionally decisions had to be made in people’s best interests. A registered manager described how a meeting had been held with the person and their social worker to make a decision about their day to day care on their behalf. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The registered manager said they were awaiting copies of the best interests decision from the social worker.

The registered manager was aware of changes in case law around the deprivation of liberty safeguards (DoLS). She confirmed no one was deprived of their liberty. DoLS provides legal protection for those vulnerable people who are, or may become, deprived of their liberty. Some restrictions were in place such as the use of bed sides to protect people from falling out of bed. People had given their permission for the use of these.

If people needed support to eat and drink this was indicated in their care plans. For people living with diabetes staff were directed about how to monitor their dietary intake if this was needed. Staff offered people choices about their food and drink discussing with them their

Good

Is the service effective?

preferences. Daily records commented on people's dietary intake and if there were concerns about dehydration or mal-nutrition these were raised with managers to follow up.

People told us staff worked closely with health care professionals such as district nurses or their GP. One relative said, "Staff are very good at picking up changes in [name] condition and report these to us straight away." Staff confirmed they spoke directly to district nurses, for example when they had concerns about a person's catheter or their skin condition. Information about people's specific conditions had been provided for staff. Guidance about when to seek emergency support was also provided.

Good

Is the service caring?

Our findings

People commented, “Care is first class. I couldn’t do any better. Absolutely superb, I would recommend to anyone”, “Wonderful, excellent, she looks after me really well”. One person who lived in a rural location described how staff had walked through snow to make sure they received their care.

People were treated with kindness. Staff were polite and courteous. They were attentive and spoke reassuringly with people. Staff took the lead from people delivering their care at the pace the person preferred. People said when they had the same staff helping them they got to know their likes, dislikes and routines. Staff paid attention to people’s needs and made sure they were happy with the care provided.

People said they occasionally had problems understanding people whose first language was not English. Other people told us this was not a problem. One person said they usually had the same carers and communication between them was good. Staff spoke clearly and listened intently to people. Conversation was animated and lively. People enjoyed the company and rapport they had with staff. One person said, “The girls are always happy and cheerful.” A member of staff commented, “We have been told to leave our problems in the car and greet people with a smile.”

A brief personal history was provided about each person. Care plans guided staff about their preferences and how they liked to be supported. Wherever possible people had staff they knew supporting and caring for them. People and their relatives said they were sent a rota each week telling them who would be working with them. One person said they did not receive a rota but staff always told them who would be coming to see them next. Staff told us about one person who had the same three staff to help with certain tasks respecting their dignity and right to privacy.

Staff discussed how they tried to give personal time to people whilst also ensuring their personal care tasks were completed. One person said, “There is never enough time. But there is nothing to worry about.” People said visit times could be challenging and they appreciated the demands on staff to meet their needs in the allocated time. People’s independence was promoted. Their care records clearly identified what they could do for themselves and what they needed help with.

People’s religious and cultural beliefs were recorded in their care plans in case they needed to be considered when delivering their care. Staff discreetly provided personal care by either closing doors or covering people when in rooms with relatives or visitors. A person said staff respected their dignity and privacy by always closing the door when they carried out personal care. Another person commented, “Absolutely excellent ..... very helpful, very caring ..... understanding, they make me laugh ..... there’s no disrespect whatsoever ... they’ve certainly got a way about them.” Other people confirmed they were treated respectfully and with kindness.

People confirmed they were involved in the review of their care. They said the care being provided reflected their wishes and the way they wanted to be supported. A registered manager said reviews were scheduled every six months or sooner if people’s needs changed. This would give the opportunity for people to express their views about the service they received. People had contact details for the office to talk with senior staff or managers. People raised concerns about difficulties getting through to the office on the telephone. The provider was addressing this. One person said managers got back to them straight away.

Personal information about people was kept securely in the office. When staff passed on information to the office this was done confidentially. Paper records were transferred between the office and people’s homes by key staff only. All staff had company mobile phones promoting confidentiality of text messages and telephone calls. A person told us carers did not mention or discuss other clients in their presence and showed respect for client privacy in this way.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed and information was provided from other social and health care professionals to determine whether their needs could be met. Individualised plans of care were based on these assessments and provided information about how they would like to receive their care and support. There were inconsistencies in the records being kept in the homes of people we visited and those maintained in the office.

People confirmed they were involved in reviews of their care and any changes in their needs were reflected in their care records. For example, staff had raised concerns about changes in a person's well-being which impacted on their moving and handling. A referral to an occupational therapist had resulted in additional equipment being provided. Care records in the office had been updated but there were no care plans in the person's home. The registered manager confirmed after the inspection these were being updated to reflect the changes and the new care plans were now in the person's home.

A person described how staff supported them to look after their skin to make sure it remained in good condition. The care plan in their home did not describe the support they were receiving from staff and when they would make a referral to district nurses. This could potentially place people at risk of not receiving appropriate care and treatment. Another person told us their draft care plan did not reflect their individual needs, so they rewrote it and returned it to the office.

Care records reminded staff to monitor people's health and well-being for example their mobility or skin condition. Any concerns had to be raised with senior staff and managers at the office so they could monitor changes. Failure to do this would result in care plans not being updated to reflect the care being provided. The registered managers said they worked closely with social and health care professionals to make sure people stayed well and their independence was maintained. Records evidenced a timely response to provide additional equipment or support from district nurses.

People had information about how to make a complaint to the provider. They also had information about other organisations they could contact if they were unhappy with the response from the provider. People who had no concerns were confident if they had any they could contact senior staff or managers. There was mixed feedback from people who had made complaints or expressed concerns. People's experience was either positive with changes being made such as replacing a carer or frustrating with a lack of response from the provider. Responses to complaints received by Cleeve Link Homecare were kept identifying the action taken. Most people said action was taken to address their concerns. For example, an electronic system used by staff to log in and out at each visit could be used to monitor the length of visits or missed visits. Internal audits were carried out where complaints were raised about staff competency such as the incorrect use of personal protective equipment.

Complaints had been received by commissioners of the service and by the Care Quality Commission. The provider had worked with us to resolve these concerns. Action was taken to improve the service provided and to learn from complaints. The provider information return stated improvements made to the service as a result of complaints included designing new medication administration records to reduce errors and providing a higher level of training for staff who need further assistance.

People received individualised care which reflected their wishes and needs. Their care plans were individualised and included a personal history, preferences and their wishes for the future. For example, people wished to remain at home and to be as independent as possible. Care plans indicated where people could direct their own care and prompt staff how they wished to be supported according to their preferences for each visit. Where people requested their personal care was delivered by male or female staff only this was respected. One person told us they only received care from female staff.

Good

Is the service well-led?

Our findings

People commented, "For the last year things have been good", "It's a lot better now" and "Overall the best DCA so far". This was not however everyone's experience and some people expressed concerns about the handling of complaints, timing of visits and consistency of their carers. Feedback from Healthwatch and local commissioners also confirmed these opinions. As a result of feedback from people using the service and staff the provider had restructured the way staff worked and travel routes. Staff were allocated to work in designated areas which in turn meant they worked more efficiently. Staff said travel time between visits was less pressurised and travelling time was considered when arranging visit times. The provider had also allocated staff who could help out in an emergency or staff sickness. Staff commented about changes to the way they worked which had improved the support they provided and the experience of people.

The registered managers and representatives of the provider said their vision and values for the organisation for the next 12 months was to create "Happy customers; happy staff." They recognised the challenges of managing a large service. They were constantly looking at "Better ways of doing things, better outcomes for clients giving them the best possible outcomes." They recognised maintaining a stable workforce was also a major challenge for them. In response they had reviewed their conditions of employment offering staff permanent contracts of employment and improving pay and career prospects within the company.

Feedback from people to us during the inspection highlighted frustrations with trying to get through by telephone to staff working in the office. Staff were assigned to answer the telephone and this was done responsively. At peak times calls were waiting to be answered. This had been recognised as another challenge for the provider and plans were in place to increase the capacity of the office to take more incoming calls and to manage outgoing calls. This would significantly improve people's experience of contacting the office.

Staff were confident any concerns they raised would be listened to and followed up. When needed action was taken to support or develop staff if their practice needed improving. The appropriate action was taken to address when staff failed to improve or breached their conditions of employment. Staff said their aim was to ensure people were safe, well looked after and happy. Their performance was monitored through quality assurance audits and spot checks. By doing this the provider had an overview of the values and behaviour of staff.

People said they were able to feedback their views about the service they received in a variety of ways. They had reviews of their care with senior supervisors, they raised concerns directly with managers and they were sent an annual survey to feedback on their experience of care. One person commented, "On the rare occasion I call the office, because of a concern or problem, [name of the registered manager] or senior staff reply to my call quickly." Another person told us, "When I do eventually speak with a manager or senior staff they are very good at getting things done."

Staff said they had access to senior supervisors, the registered managers and senior management. Monthly meetings had been set up with senior staff and senior management to provide a forum to discuss and share their visions for the service. Registered managers also had monthly meetings with senior management to discuss service changes and improvements.

The registered managers for Cleeve Link and Live in 24 were aware of their responsibilities and legal obligations. The Care Quality Commission had received statutory notifications promptly. Services tell us about important events relating to the service they provide using a notification. They had also liaised with other agencies and responded to their requests for information. The local authority confirmed complaints raised with them had been discussed with Cleeve Link Homecare. Issues raised with us (the Care Quality Commission) during the inspection were fed back to the registered managers. They responded promptly to deal with these concerns.

A range of quality assurance systems were in place such as monitoring care plans and visit rotas, observing care being provided and inviting feedback from people, their relatives and staff. These along with an analysis of accidents, incidents and complaints were used to drive improvements in the service and the experience of people.

Registered managers and the provider kept their knowledge and practice up to date through involvement with a local care providers' association and the local authority. The provider information return stated, working

Good

Is the service well-led?

with other organisations “promotes consistency and continuity of good practice” and “managers closely share knowledge to promote good and consistent leadership”. A staff newsletter was used by the service to share good practice.