Care Quality Commission

District Carers Limited

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Inspection report

Hangleton Nurseries
Hangleton Lane
Ferring
West Sussex
BN12 6PP

Tel: 01903507801

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 15 and 16 June 2017 and was announced.

District Carers Limited provides personal care to people care in their own homes. At the time of the inspection personal care was provided to 123 people whose ages ranged from 42 to 99 years and had needs such as physical disability, sensory impairment, dementia and frailty due to old age.

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.

At the previous inspection of 3 May 2016 we found the provider had not ensured assessments of risk were adequate to ensure those risks would be mitigated. We made a requirement for this regulation to be met. The provider sent us an action plan of how this was to be addressed and at this inspection we found the regulation was met.

At the previous inspection of 3 May 2016 we recommended the provider put in place a plan for formal supervision of staff as we found staff supervision was inconsistent. At this inspection we found staff supervision was well organised and included observations of staff working with people in their homes to check their competency. Staff told us they felt supported in their work.

Since the last inspection the provider has implemented an IT system whereby each staff member has smart phone which included all the relevant information about their daily work including people's care plans. Staff completed their daily records on these. The system had a number of benefits to people, staff and the management; for example people and relatives could make comments by directly accessing the records. We noted the system needed to have time to embed as there were a few problems with it. These included staff not being able to fully access the system at times due to poor connectivity. We also noted the IT records did not always have details of people's medicines. We have made a recommendation regarding the monitoring of care and medicines records.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People said the staff provided safe care.

Sufficient numbers of staff were provided so people's care needs were safely met. People commented that care staff attended at the agreed times. Since the last inspection we received two complaints that staff did not always attend to people at the agreed times. We looked into this during the inspection by asking people about this and by looking at records; these allegations could not be substantiated. We sent surveys to people to ask for their comments about the service; one person and one relative said they did not always get a weekly rota supplied. We spoke to six people or their relatives and these all confirmed they received a

weekly rota detailing which staff were coming to see them.

People generally received their medicines safely, although we noted the record system used by the staff did not always detail people's prescribed medicines which staff needed to administer. This was isolated to two occasions and is referred to in the Well Led section of this report.

Staff were trained in a range of relevant subjects such as moving and handling, dementia awareness, infection control, the Mental Capacity Act 2005 (MCA) and food hygiene. Newly appointed staff received induction training to prepare them for their role.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005. The service had policies and procedures regarding the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff were trained in the MCA and had a good awareness of the legislation. People were consulted and had agreed to the arrangements for their care

People were supported with the preparation of meals where this was needed.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed.

Staff had positive working relationships with people. Staff acknowledged people's rights to privacy and choice. People told us how staff treated them with kindness with compassion. Staff said they treated people in the way they would want a member of their family, or themselves, treated. Staff listened to people and treated people in a way which made them feel valued.

The service had a complaints procedure, and people said any concerns or queries were responded to.

People were involved in discussions about their care and said their needs were met. The staff regularly reviewed people's care by visiting them in their homes. People told us the staff spent time talking to them after the care tasks were completed which they enjoyed.

People and their relatives' views were sought as part of the service's quality assurance process.

The registered manager understood their responsibilities to report specific incidents to the Commission but had not done so for one investigation.

There were a number of systems for checking the safety and effectiveness of the service such as regular audits. Staff said they were supported by the management team.

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.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and guidance recorded so staff knew how to reduce risks to people.

Staffing was provided to meet people's assessed needs.

People received their medicines safely, although we identified the care records were not always up to date.

Is the service effective?

Good

The service was effective.

Staff were trained in a number of relevant areas and had access to nationally recognised qualifications in care. Staff were supported by regular supervision and appraisal of their work.

People's consent was obtained before staff provided care. The service had policies and procedures regarding the Mental Capacity Act 2005 (MCA) and staff had a good understanding of the principles of the MCA.

People were supported with eating and drinking where this was needed.

Health care needs were monitored and people were supported so they received the appropriate health care.

Is the service caring?

Good

The service was caring.

Staff had values of compassion and treated people with dignity and respect. Staff had good working relationships with people and provided care in a way which made people feel they

mattered.

People were involved in decisions about their care which was personalised to meet needs and to suit people's personal preferences.

People's privacy was promoted in the way they were treated by staff.

Is the service responsive?

Good

The service was responsive.

People's needs were comprehensively assessed. Care plans were of a good standard with details of how people needed to be supported. People were consulted about their care.

People's social needs were assessed and staff provided people with companionship.

The service had a complaints procedure and people knew what to do if they wished to raise a concern. Records showed any complaints were looked into, although people and their relatives gave mixed views about whether their complaints were dealt with to their satisfaction.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A new system of recording people's care needs had a number of advantages so staff, people and relatives could access and record information. The system, however, had some shortcomings which needed to be addressed.

The service sought the views of people as part of its quality assurance process.

There were a number of systems for checking and auditing the safety and quality of the service.

Care Quality Commission

District Carers Limited

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. The 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.

This inspection took place on 15 and 16 June 2017 and was announced. We gave the provider 48 hours notice of the inspection because it provided personal care to people in their own homes so we needed to be sure the registered manager or staff were in the office.

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 any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

The inspection was carried out by one inspector.

During our inspection we looked at care plans, risk assessments, incident records and medicines records for six people. We looked at supervision, training and recruitment records for staff and spoke to four staff. We also looked at a range of records relating to the management of the service such as complaints records, quality audits and policies and procedures.

We visited two people in their homes at the time staff were attending. We spoke with six people (or their relative) who received a service from District Carers Limited to ask them their views of the service they received. We sent survey questionnaires to 50 people and to 50 relatives of people to ask them for their views on District Carers Limited. Fifteen surveys were returned by people and three by relatives. We also received a survey questionnaire from a health and social care professional.

We also spoke to a commissioner from the local authority who monitored the provider's standards of care and purchasing arrangements for care.

Good

Is the service safe?

Our findings

At the previous inspection of 3 May 2016 we found the provider had not ensured all the risks to people were identified and assessed and that there was insufficient guidance for staff on how to mitigate these risks. We made a requirement for this to be addressed and the provider sent us an action plan of how they would ensure this regulation was to be met. At this inspection we found improvements had been made and this regulation was now met.

We looked at care records for six people and saw risks were assessed regarding a range of needs. These included a health risk assessment, risks of skin damage from prolonged immobility and moving and handling assessments. There were also assessments regarding any risks associated with food and drink such as problems caused by swallowing difficulties or choking hazards. There were care plans to show the action staff needed to take to minimise these risks, such as instructions on safe moving and handling. The need for checks on skin areas was recorded and there was diagram for staff to consult of those areas to check where there was a possibility of skin damage. Other actions such as applying skin creams were recorded as being needed to help keep skin intact. We also saw risk assessments regarding the safety of people when in bed were well recorded, such as for the safe moving and handling and for the use of bed rails to stop people falling out of bed. Risk assessments were also carried out regarding any environmental risks to people and staff.

People told us they received safe care. For example, one person said, "The staff help me with my mobility. They are patient and wait for me. They don't hurry me." A relative said they felt reassured by the care staff who they trusted and gave an example when staff dealt with an emergency and called the ambulance service. All of the people who returned a survey questionnaire said they felt safe from abuse or harm from care workers. This was also echoed in the responses from relatives and a community health and social care professional.

The service had policies and procedures regarding the safeguarding of people which included the local authority guidance. Staff were aware of their responsibilities to report any concerns of a safeguarding nature to their manager and knew they could also make contact with the local authority safeguarding team. Training was provided for staff in safeguarding procedures and this was also included in the induction of newly appointed staff.

Sufficient numbers of staff were provided by the service to meet people's needs. People said they generally received a reliable service and that care workers arrived promptly and stayed for the agreed length of time. There were some exceptions to this. For example, two complaints were made to the Commission since the last inspection which said staff did not always attend calls. Each of the people, and their relatives, we spoke with said staff always attended to care appointments as agreed. We checks the records of six people's care appointments made by staff when they visited people and found these reflected what was recorded in the care plan. We also saw records of care reviews where people had confirmed they were satisfied with the reliability of staff. We also looked at the records of appointments for a seventh person as a complaint was

made. We found one morning visit was not completed until approximately three hours after it was scheduled. This was discussed with the registered manager who looked into the call times for the person who confirmed there was no known reason for the appointment being adjusted. This one identified gap in meeting appointment times needs to be seen in the context of the records showing appointment times for other days were met.

The provider's policy was to supply people with a weekly timetable of the times and names of staff who would be attending to them. One relative and one person who returned a survey questionnaire to us said they did not always receive a weekly timetable even when they asked for it to be emailed to them. Each of the people, or their relative, we spoke with said they received a timetable. People also said they were notified if there were any changes to their care timetable although three people, or their relative, said they were not always informed of these changes.

Care appointments were organised on a duty roster for staff which they accessed via a smart phone supplied by the provider specifically for their job. This required staff to 'check in' and to 'check out' when they provided care to someone. The system also gave a distance of where the staff member was from the person's home so a more accurate check could be ascertained. Staff said this system worked well with the exception when there was an interruption in the updating of the records due to connection issues. Staff said they had sufficient time to complete their tasks and to travel to the next person. In addition, staff said they were supported by the management to spend more time with people if this was needed.

We looked at the staff recruitment procedures for two staff who had recently started work for the provider. References were obtained from previous employers and the registered manager carried out telephone reference checks in addition to written reference returns. Disclosure and Barring Service (DBS) checks were made regarding the suitability of individual staff to work with people in a care setting. Records showed prospective staff were interviewed regarding their suitability to work in care.

The provider used an assessment tool to check what level of support people needed so they got their medicines safely. People's care plans included a medication risk management and agreement plan. The level and type of support people needed was recorded in each person's care plan. For example some people were assessed as being able to handle and administer their medicines whilst others needed staff to support them with taking their medicines. These assessments were reviewed and updated. Where staff supported people to take their medicines a record of this was maintained on a medicines administration record (MAR) which was contained within the computerised records accessed by staff on the smart phone. We noted there were some anomalies in the medicines records. For example, one person's medicines risk assessment said they needed 'special techniques' to administer pain relief medicine. However, there was no record of this on the person's records or the dose and frequency or any record of it being administered. The registered manager and staff took immediate action to address this, which was attributed to information not being entered correctly on the new computerised records. Following the inspection a staff member said they had not given someone their medicine as it was not on the person's records. The staff member thought this may be due to the IT system not updating itself correctly. This was raised by the staff member with the registered manager who confirmed this was immediately corrected and action taken at the time to ensure the person received their medicine. This is also covered in the Well Led section of this report.

The service had policies and procedures regarding the handling, administration and disposal of medicines. Staff were trained in the safe handling of medicines which included observation and assessment of their competency before being permitted to do so.

Good

Is the service effective?

Our findings

At the last inspection we found the arrangements for staff supervision and appraisal were inconsistent amongst the care staff. We made a recommendation for the provider to put in place a plan for regular formal supervision of staff. At this inspection we found staff received a combination of spot check observations of their work with people, supervision meetings, appraisals and telephone call checks on their work. The competency of new staff was assessed following an induction called a, 'probationary review.' Supervision was provided by a team of four senior care staff and supervision sessions were well recorded. Staff confirmed they received regular supervision and that their work with people was checked by observations of them. Staff said they had regular supervision and that this involved observations of them working with people. For example, one staff member said, "I've had two supervisions in the last three months including a field observation spot check which covered an assessment of me handling medication." Staff also said they felt supported and one staff member said, "I can ask for advice. There's always someone I can talk to and it always gets resolved."

People and their relatives considered the staff were skilled in providing the right care. Each of the people and their relatives said the care staff had the skills and knowledge to provide the right care and support. One relative described the care staff as, "Absolutely amazing. They go beyond just providing care. I am confident the right care is provided." People and their relatives said the care staff completed all of the tasks they should during each visit.

People told us they were consulted about their care and that that their care was reviewed with them. People had signed their care plans to acknowledge they had agreed and consented to it. People gave mixed views about whether they knew or had seen a copy of their care plan. One person told us they were able to access the care plan via the provider's IT system and another person did not know whether they had a care plan or not as they had never seen one.

Newly appointed staff received an induction to prepare them for their role. This involved enrolment on the Care Certificate. Records of staff induction were maintained. The induction included training in areas considered mandatory to the role of care worker such as moving and handling, safeguarding, infection control, record keeping, dementia awareness, moving and positioning, confidentiality, food and nutrition and first aid. Staff confirmed they received an induction before they worked independently and that this involved a period of 'shadowing' more experienced staff followed by an assessment of their competency.

The service had a staff member responsible for coordinating training of staff. Each staff member had a record of training. The provider confirmed that there were 56 care staff and that 19 had attained the National Vocational Qualification (NVQ) or the Diploma in Health and Social Care level 2 and 13 at level 3. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Staff confirmed they were trained in a range of relevant subjects which consisted of 'on line' training or class based. Staff also told us they were able to discuss their training needs at their supervision.

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.

Staff were trained in the MCA and knew the basic principles of the legislation and of the need to gain people's consent before providing care. People said they were involved in any decisions about their care and we saw this was recorded in people's care plans.

Where applicable people's care records included details about any dietary needs and support to prepare meals. Risks regarding food and drinks were assessed and care plans showed the support staff needed to give, such as which meals needed to be prepared throughout the day. People said they were supported with food and drink when this was needed. For example, one person said the staff made sure they had plenty of drinks and we observed this person had access to cold drinks. Records were maintained of the food and drink people had where this was needed.

Care records showed people's health care needs were monitored and that care staff liaised with community health care professionals when needed. There were health risks assessments and people's mental health needs were also assessed.

Good

Is the service caring?

Our findings

People spoke highly of the care staff who they said treated them with kindness and dignity as well as involving them in decisions. The comments made by people and their relatives included the following, "The staff are very nice. Very very kind. I can get on well with them. I get to know them and they get to know me. They are very caring and respect my privacy and dignity." Another person said of the staff, "They are all lovely. All of them." A relative described the staff in the following way, "They're really lovely, but professional. Always clean and tidy. They are friendly and like to sit and have a chat with mum/dad." Another person said they received care from a consistent team of care staff which helped the staff to get to know the person well.

Staff promoted people being able to make choices about how they were assisted and consulted them. For example, we observed a staff member talking to a person they were supporting; the staff member asked the person how they wanted to be helped and consulted them. This person said they were very pleased with the staff attitude which they said was, "Caring. I can't praise them enough." This person described the staff as friendly, attentive and communicated well with them. Care records also showed people were involved in decisions about their care.

Staff demonstrated they had values of compassion and of treating people in a way which made people feel they mattered. For example, staff said they treated people in the way they would like to be treated themselves or how they would like a member of their family treated. Staff said treating people with dignity and respect was integral to their work. One staff member said they provided care and support by making sure they completed all the tasks by providing more than was needed as this made people feel they were important.

The provider's policies and procedures, as well as the staff handbook, emphasised people's right to privacy and independence. There was a code of values, which said people should be treated as individuals and their lifestyle respected. These values were demonstrated by staff who know people should be offered choices and their independence promoted. People's lifestyle preferences and social needs such as any religious observance were recorded in care plans. People were able to choose the gender of the care staff who supported them and these preferences were recorded in care plans.

Good

Is the service responsive?

Our findings

People and their relatives told us District Carers Limited provided a responsive service, which reflected their needs and preferences.

We observed a care worker speaking to a person about what type of support they would like. The staff member responded to the person's requests. The staff member was observed to support the person with more domestic tasks in addition to the personal care. These included preparing food and washing clothes. This person expressed their satisfaction with the care and support they received and said the arrangements were structured to reflect their own routines.

People's care needs were assessed and reviewed at intervals. People confirmed they were visited at home by one of the provider's management team to discuss their care needs and any changes that were needed or suggested. Care records included details of these reviews. People told us the provider was flexible in adjusting care to suit their changing needs or preferences.

Assessments of need and care plans were comprehensive and reflected people's preferences. Each person had a care plan 'over view' which summarised the person's care. People's daily routines were recorded as well as their preferences of how care should be provided. Assessments of need and care plans covered mobility, eating and drinking, mental health, physical health, communication and skin care. The details of the times of care were recorded and records showed that on the whole care was provided as agreed with people. Care plans were signed by people to acknowledge they were in agreement with its contents.

The care plans, medicines records and records of care completed by care staff each time they visited someone were held on a specifically designed smart phone supplied to each staff member. Information such as care plans and care times was inputted onto the devices by members of the management team. The system allowed people and/or their relatives to access these records via the provider's care record system. We saw how one relative had done this and had made a comment about the person's care. This system had a number of advantages such as making information more readily accessible to staff, people and their relatives. We identified some shortfalls in the system, which are detailed in the Well Led section of this report.

People's social needs were assessed including mental health needs. People told us the care staff spent time talking to them, that they viewed them as people they knew and got on well with which provided them with companionship.

People said they felt able to raise any concerns or requests they had which were responded to. For example, one person said they had raised "a couple of complaints," which were quickly rectified. However, the survey responses we received from people showed 33% of people did not feel the agency responded well to any comments or concerns raised.

The complaints procedure was included in the information supplied to people so they had the details of

who to contact.

The provider maintained a record of any complaints. In the 12 months preceding the inspection 10 complaints were made to the provider. There was a record to show these were acknowledged, looked into and a response made. The records showed action was taken by the provider to address the concerns such as a request for a change of care worker or a complaint about the times of care.

Requires Improvement

Is the service well-led?

Our findings

The technology used to record the care people received also permitted people and their relatives to make direct comments about care. We saw a positive comment from a relative regarding the way staff treated their relative, which the relative had entered onto the records. The IT system used for care records had many positive features such as staff having immediate access to care records and their scheduled care calls for the day. Staff showed us how the system worked and the records they accessed. Staff activated an icon on the records to show when they arrived at someone's house and when they left, which allowed the management to monitor care calls were being made. However, staff said the system did not always make a connection, which could mean the visit would not be entered on the system as the connection was lost. We saw a record of a care call not being completed as the connection signal was lost. We also noted there was an absence of a pain relief medicine for one person in the person's care records. There was no record of what the medicine was, or the dose or how often it needed to be taken. The daily records completed by staff said, 'patch changed,' which indicated the person received the medicine. The omission in the records meant there was a risk the person might not receive their medicine as staff may not know it was to be given. This was discussed with the registered manager and a senior care staff member and action was taken to address this. We also became aware after the inspection of another error where the medicines to be prescribed were not included in the IT records. The staff member said the lack of records led to them not knowing what medicine the person needed to take. We spoke to the registered manager about this who confirmed action was taken to rectify this at the time so the person received the medicine. These shortcomings show the system of care records needs time to embed and requires additional checks to ensure information is always accurately recorded. This was discussed with the provider and registered manager who were aware of the need to refine the system. We recommend the provider's quality assurance system monitors the system of recording people's care, including medicines and records of care appointments and takes appropriate action to ensure these are accurate in order that people always receive safe care.

People and their relatives gave mixed responses regarding the management of the service; these were generally positive but there were some exceptions to this. For example, one person said, "The carers are very nice. The information we receive from the office is not good. I often do not receive a rota for the week and they never contact me if there is a change to the times given." A relative also made the same comment. These comments were in contrast to others which were positive about the service, its reliability and that any changes were communicated well.

The provider sought the views of people who received a service by a satisfaction survey questionnaire. However 53% of the 15 people who returned a survey to us said they were not asked by the provider to give their views about the service. We saw comments from people who had completed the provider's feedback included the following, 'Friendly staff,' 'Observant provider,' and 'Good communication.' The provider also told us the views of people were sought by telephone questions to check the standard of care being provided and that the questions were based on the Care quality Commission Key Lines of Enquiry (KLOE). The provider said they planned to contact all people to conduct a telephone survey.

Since the last inspection the provider had completed an investigation on behalf of the local authority

safeguarding team where a concern was raised. As a result of the investigation the provider had taken action to provide additional training for staff. The provider should have notified the Commission of this investigation but had not done so as the registered manager thought they did not need to as social services had raised the concern. The need to notify the Commission was discussed with the registered manager who understood their responsibilities.

Staff said they were well supported and had time to complete all the scheduled care tasks without being rushed. One staff member said it was the one of the best agencies they had worked for and another staff member said of the service, "The agency cares for people." Staff also said they were able to discuss any issues about their work at supervision and team meetings.

There was a system of delegation and management whereby a team of five senior staff had responsibility for supervising a team of care staff. There was a full time staff member with responsibility for providing and coordinating staff training; this staff member said staff training was well resourced so staff had access to the training they needed. There was also a team of coordinators and administrative staff to arrange the appointments of care.

Audit checks were made on care plans and staff records and there were actions to improve and update these if needed. The audit checks on staff files were comprehensive. Records were maintained of any incidents or near misses such as errors in the administration or handling of medicines. These showed an investigation took place along with an action plan to address any mistakes.