Pentlow Community Care Limited

Pentlow Community Care Limited

Inspection report

13A Gildredge Road
Eastbourne
East Sussex
BN21 4RB

Tel: 01323431810
Website: WWW.pentlowcommunity.co.uk

Date of inspection visit:
28 March 2017

Date of publication:
10 May 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Pentlow Community Care is a domiciliary care agency providing care and support to older people, people living with dementia and physical or sensory impairments in their own homes.

This comprehensive inspection was undertaken on 28 March 2017 and was announced.

Since the last inspection the registered manager had resigned and the service did not have a registered manager in post. Currently an acting manager was in day to charge. The acting manager had commenced the registration process with CQC to become the registered manager. A registered manager is a person who has registered with the 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 2008 and associated Regulations about how the service is run.'

We received positive feedback from people receiving care, relatives and staff regarding the day to day management of the DCA. The acting manager had implemented a programme to ensure staff recruitment, induction and supervision was robust and on-going. Staff received training to ensure they were appropriately trained to meet people's needs. Staff training was assessed during spot checks and competencies to ensure that best practice was followed and maintained at all times.

People received care based on their individual needs and preferences. An initial assessment took place to identify people's needs and to ensure the service were able to meet these. Risk assessments were in place for individual and environmental risks. Care and risk was regularly reviewed and changes made if required. Staff told us how they ensured people's safety was maintained and demonstrated a clear understanding regarding safeguarding and how to report if needed.

Medicine processes were in place and these were audited regularly. Staff medicine competencies were completed and people told us they were happy with the way their medicines were managed.

There was a system in place to continually assess and monitor the quality of service provided. Audit information was used to continually improve and develop the service. Accidents, incidents and falls were audited and analysed. The acting manager told us how they used this information to identify any trends or themes.

People were actively involved in day to day choices and decisions. Staff and management had completed training around mental capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS). Some information was stored on the computer regarding people involved in decisions regarding peoples care. The acting manager told us they would add any relevant information to care records to ensure all staff had access to this information.

People who required assistance with shopping or meal preparation had this provided. Information was in

place to inform staff of people's nutritional needs. Guidance was in place from other health professionals when appropriate and staff were able to tell us about people's needs. Staff were aware that people may become lonely or isolated and tried to support and encourage people to continue with activates to prevent this.

Care was person centred. People and their next of kin if appropriate were involved in reviews about how care was provided and people felt involved in choices and decisions made about their care and day to day activities.

A complaints procedure was available for people to access if needed. People told us if they had any concerns they contacted the office and they always received a prompt response. People were encouraged to provide feedback about the service they received. Information fed back was used to make changes and improvements.

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

Pentlow Community Care was safe

Staff had appropriate information and equipment in place to support people safely and demonstrated a good understanding of how and when to report safeguarding concerns.

Medicines were well managed and people received the medicines they had been prescribed.

Systems were in place to report and respond if there were any accidents, incidents or falls.

There were enough staff who had been safely recruited to meet the needs of people who used the service.

Is the service effective?

Good

Pentlow Community Care was effective.

Staff had received training to ensure they had the knowledge and skills to meet the needs of people they visited.

Staff felt supported and had regular supervision. New staff completed a period of induction and training before working unsupervised.

People were actively involved in day to day choices and decisions.
Management and staff had an understanding of mental capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS).

People who required assistance with shopping or meal preparation had this provided. Information was in place to inform staff of people's nutritional needs.

People's health was supported; referrals were made if staff identified any concerns or when people became unwell.

Is the service caring?

Good

Pentlow Community Care was caring.
People told us staff were very caring and supportive.

Care was provided in a kind and compassionate way, involving people and helping to maintain their independence.

People's privacy and confidentiality was maintained.

Is the service responsive?

Good

Pentlow Community Care was responsive.

Care was person centred. People and their next of kin if appropriate were involved in reviews about how care was provided.

People were involved in choices and decisions made about their care and day to day activities.

A complaints procedure was available for people to access if needed.

Is the service well-led?

Good

Pentlow Community care was well led, there was currently no registered manager in post. The acting manager was in day to day charge of the home and in the process of registering as manager with CQC.

People, relatives and staff told us the agency was organised and well led.

Staff were supported and communication had improved to ensure staff felt involved and their views listened to.

There was a system in place to continually assess and monitor the quality of service provided. Audit information was used to continually improve and develop the service.

People were involved in gaining and providing feedback about the service they received. Information fed back was used to make changes and improvements.

Pentlow Community Care 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. 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 which took place on 28 March 2017 and was announced. We contacted the agency 48 hours prior to the inspection to ensure there would be staff in the office when we did the inspection. The inspection was carried out by an inspector and expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who used this type of service.

This was the first rating inspection for this service.

Before our inspection we reviewed the information we held about the Domiciliary Care Agency (DCA). We looked at information and notifications which had been submitted by the service. A notification is information about important events which the provider is required by law to tell us about. We also reviewed any other information that had been shared with us by the local authority and quality monitoring team.

We spoke with nine people who use the DCA and one relative, seven staff including the operations and acting manager, administration and care staff.

We spent time looking at care records for three people to get a picture of their care and support needs and how these are met. We also looked at documentation in a further one care file to follow up on a specific health condition and areas of care for people, including risk assessments.

Medicine Administration Records (MAR) charts returned to the office were checked. We read daily records and charts and other information completed by staff. We reviewed four staff files and other records relating

to the management of the DCA, such as accident / incident recording, training and supervision planning, quality assurance and audit documentation.

Good

Is the service safe?

Our findings

People told us they felt safe receiving care in their homes from Pentlow Community Care. Telling us, "'Very safe, they are very good people, they are very good, they know their job I don't have to tell them." "I've got a history of falls before I broke my hip. There is always one of them here when I move about the house; there is always a carer behind me." And one relative told us, "Very safe, they are very careful. There is a moving and handling plan all written up in the book. When they come in they always consult the book. They are really careful."

Staff told us they felt well informed and supported to provide care for people. A full assessment was carried out before people began receiving support from care staff in their own homes. These included information about people's health and mobility for example whether they were independent or used walking aids. Staff had access to up to date information and risk assessments to ensure they were aware of any identified areas of risk, both relating to the individual and the environment. Individual risk assessments included pressure area risks, risk of falls, urinary tract infections, infection, nutrition and swallowing concerns and mobility risks. Environmental risk assessments identified, any aspect of the person's home which may present a hazard to them or staff. For example, safe access to the persons home, condition of the home and equipment used by care staff within the persons home. Staff confirmed that they had access to the appropriate moving and handling equipment for people to keep them safe and were able to collect all infection control equipment including gloves and aprons from the office whenever needed to ensure that infection control measures were followed at all times.

There were systems in place to support the safe management of medicines. Some people did not require help with their medicines and told us they looked after their medicines themselves. Those who did require prompting or assistance told us, "I have a whole series of tablets I have to take and eye drops. They have a series of forms they fill in, they fill them in religiously." "They do the ordering and make sure the surgery issues the correct prescriptions, they make sure I don't run out of anything."

Medicine administration record (MAR) charts were completed to show people had taken their medicines as prescribed. MAR charts were checked and audited once returned to the office to ensure they had been completed accurately and reflected the medicines people were taking. Any discrepancies found were addressed immediately. Where people had been prescribed a varying dose of medicine or medicines that were not required every day this was recorded in the daily records by care staff to show what medicine had been given, the dose and the reason. We discussed with the acting manager that this information should be recorded for clarity on the rear of the MAR chart to give a clear record on the MAR of what medicines people had been given. The acting manager told us they would advise staff to complete this immediately.

There were clear guidelines in place about medicines. Staff were aware, for example, that only medicines that had been prescribed and were on the MAR chart could be given. Some people required skin creams. There was guidance in place for all creams and a coloured body map to clearly indicate how and where creams should be applied.

Staff were clear of their responsibilities regarding medicines and told us if they felt that someone needed medicines from the GP or a medicine was not working effectively or causing any issues or irritation they would pass this to the office immediately or call the persons GP. Staff told us medicine information and risks were documented and they had all the information in place to support them to give medicines safely and appropriately.

People were protected, as far as possible, by a safe recruitment practice. Records seen included application forms, identification, references and a full employment history. Each member of staff had a disclosure and barring checks (DBS) these checks identify if prospective staff had a criminal record or were barred from working with people. These checks took place before staff commenced working unsupervised. Staff were required to drive as part of their employment. There were annual checks to ensure staff had appropriate car insurance in place for vehicles used at work.

There were enough staff to meet people's needs. Before accepting people to use the service a full assessment was completed to ensure they were able to meet their needs and to ensure adequate staffing levels. Some people required two staff during some or all visits to assist them with mobility and personal care. Relatives confirmed that their loved one required two staff to assist with moving and hoisting at that this always took place. Staff told us that they felt they were given sufficient time with people and that time allocated between visits was normally sufficient. We were told that on occasion due to traffic or if they had to stay with a person due to illness or an issue occurred, they would contact the office or the next person directly to ensure they were aware they would be late.

The acting manager told us that there were sufficient staff to cover for annual leave and sickness. Staff confirmed that they were offered overtime to cover and were able to do this if they wished. If there was an occasion when care staff were unable to cover a shift at short notice all office staff including the acting manager were care trained and able to go out to complete home visits if needed.

Staff had a clear understanding of different types of abuse, how to identify and protect people from the risk of abuse or harm. This included ensuring people were safe in their own homes and were not for example, at risk of self-neglect. Staff had access to information and appropriate safeguarding training. Staff told us all concerns would be reported to the acting manager or office staff. However, staff were aware of the importance of ensuring concerns were reported to outside professionals if necessary. Staff were aware they could do this directly if needed. Staff gave us examples of when they had needed to raise concerns to ensure the person was safe and protected.

Accident and incidents were recorded with a system in place to show what had occurred and actions or outcome after the event. We saw examples of when incidents had occurred and the steps taken by staff and the acting manager in response. This included observations after a fall or injury, reporting to the local authority and or further referrals for example to the persons GP. All accidents /incidents were recorded in daily records and reports were added to a register of concerns by office staff. This information was analysed to identify any trends or themes. All staff we met told us the process they followed if an incident or accident occurred. People told us they felt safe as staff always made sure they were safe or received the help they needed.

Good

Is the service effective?

Our findings

We received very positive feedback regarding the care people received. People felt that staff were knew them well and provided care in the way they chose. Telling us, "They are very observant, I know when they come in the door that they have a good look at me. If I needed a doctor they would call one." People felt staff were trained to meet their needs, one said, "They take their NVQ, I'm not sure how that works. They have to learn about giving out medication, things like that'. Before someone new comes in there is shadowing. If I had a particular thing that happens they come around and show the other one."

People were supported to have access to healthcare services and maintain good health. Staff were clear that it was their responsibility to ensure that the appropriate professionals were contacted to maintain people's health. Referrals had been made to other health professionals when required, this included GPs and district nursing teams. People confirmed that care staff responded promptly to any concerns, telling us, "I had a very nasty cough at one time and they organised a home visit by the Doctor, another time they noticed a nasty break on my leg and they called the District Nurse. The system worked." One person told us that care staff had noticed she was unwell and thought she may have a specific infection and had organised a GP visit, the GP had then diagnosed and treated this health condition. The person told us, "The doctor was amazed this had been noticed."

People received care from staff who had knowledge and skills to look after them. There was a training programme which included all essential training for staff. Training took the form of both e-learning and practical sessions. This included training to maintain skills and competencies, and specific health related training for care staff which included dementia, infection control and moving and handling. Staff told us they had received all the training they felt they needed and that they were aware that further training and updates were always available to ensure they could continue to carry out their roles effectively. One staff member raised that practical moving and handling sessions involved quite a large group and they felt that smaller groups would mean all new staff had the opportunity to practice with equipment. This was fed back to the acting and operations managers who told us they would take this information back to the trainers.

Staff felt supported. One told us, "The overall management situation is a lot calmer now, things are so much better." Staff confirmed that they felt supported and able to raise any issues or concerns with the acting manager and that the support in the office from all senior staff was effective. One told us, "The acting manager has been working so hard to get everything sorted."

A programme was in place to ensure staff received regular supervision from a senior member of staff. Staff told us they received supervision and used these as an opportunity to discuss any issues or future development they wished to complete. For example, further health related training. All supervisions and appraisals were documented and staff knew when they were due to take place. Minutes of all supervisions were signed by staff with any actions to be taken forward recorded.

When new staff were employed they completed a full induction this included a number of topics to be covered during the induction period including safeguarding, how to understand the roster, documentation

and forms to be completed by staff, shadowing checklist for completion and understanding care documentation. Inductions also included training and shadow shifts when new staff shadowed a permanent experienced staff member. New staff were assessed to ensure they had the understanding and skills before they worked unsupervised and induction periods were flexible dependant on the individual. Staff told us, "I had a good induction, I felt supported."

Staff were provided with training around Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and what may constitute a deprivation of liberty. The acting manager and staff demonstrated an understanding of MCA and its aims to protect people who lack capacity and when this might be required. The Care Quality Commission has a legal duty to monitor activity under DoLS. This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests. We discussed with the acting manager how people were involved in decisions regarding the care and support provided. The acting manager was able to tell us detail regarding who had a power of attorney (LPOA) or designated persons involved in decisions around people's finances and decisions. This information was recorded on the computer system; however, not all of this information was clear within peoples care files. The acting manager advised us they would ensure this information was also recorded within care files to ensure that this was available for all staff.

Staff were clear regarding peoples involvement in decisions and that consent was always gained before care was provided. People confirmed that staff involved them and listened and respected their decisions. Telling us, "Everything is done as I want it." And, "They always get my permission first." Staff were clear that people were supported to be involved as much as they possibly could. For example, people were supported to make choices about the clothes they wore, what they ate and how they spent their time. The acting manager told us that during the initial assessment people were asked what time they wanted their visits. If this could not be accommodated people were told the time that visits could be arranged and asked if they were happy with this. This was because the request for some specific times in the morning and evening were extremely popular and the service could not meet everyone's requests. As soon as a space was available this would be communicated to the person and they could have their visit time moved if they chose to.

People were given a roster each week to ensure they were aware of who was going to be visiting them in the forthcoming week. People told us, "It comes every Friday morning by first class post. If the post is late all I have to do is ring the office'. She said 'The right carers come." One person told us that they received their rota each week, and, "Due to my poor eyesight, one of the girls gets a very thick pen and writes things up for me so I know who's coming to me. That's good isn't it? They let me know if they are going to be late, they do let me know so I don't worry." If staff were going to be delayed people were kept informed. "There is always something that can happen at the last minute, they can't always arrive on time, they are not given a lot of time to travel in between. The traffic can be a problem. Generally speaking if they are going to be very late somebody lets me know. I can always phone the office and they check up. People felt that there was consistency of staff on most occasions. One person told us, "There's three of them that come on a regular basis. Of course, you see, they have days off and we have whoever is available. It always works out." And, "I have the same carer except for her day off. I like continuity."

People who required assistance with nutrition had this provided. Care plans included specific information with regards to peoples, likes, dislikes, allergies or specific nutritional needs. For example, one person had been seen and assessed by Speech and Language Therapy (SALT). Guidance was recorded to inform staff that they required their fluids to be thickened and the consistency this should be. Information was also in place regarding how food should be prepared to aid swallowing issues due to dementia. Records were in place to record what people ate and drank if appropriate. One person told us , 'I am on a liquid chart at the moment, they say 'have you had your drinks'. They record it, I'm not sure where they record it but they

absolutely do."

Some people required staff to buy food, prepare meals, or leave them with food and drinks for after the visit. People told us staff asked what meals and snacks they wanted. "For breakfast they bring me cornflakes and fruit. At tea time they will do me bacon butties, toasted teacake, they have brought me in chips which I have with a boiled egg, they leave me with half a buttered hot cross bun and milk at night." People confirmed they are left with drinks to ensure they stay hydrated and that staff will always make them a cup of tea or snack if they ask for one.

Good

Is the service caring?

Our findings

People told us they felt well looked after and that staff were kind and caring. "I know them all now they are lovely girls." "I wasn't all that good yesterday, they listened to what I had to say, they made me a cup of tea and chatted." People felt that staff had the time to provide care and were always supporting. "I'm very happy; they give me confidence to carry on. They don't mind what they do or how long it takes to do it'."

People confirmed staff treated them with respect and that their dignity was supported at all times. People were supported to maintain their independence and their views respected. "We are working together, I think if somebody decided to take over, I would feel useless, they know me." Staff told us they were always respectful as 'they were in the person's home'. People confirmed that staff showed respect for their belongings and were always considerate. "They treat you and your things with respect; they couldn't do more if it was their own property." "They always come in with a smile, they call me by my first name (confirming her preference), I know their first names we are on first name terms." One person told us they had male carers but that was generally when they needed help with mealtimes and they had confirmed this was suitable. "If one objects to a male carer they would immediately replace it with a female carer." Another told us, "I did have gentlemen, they did phone to ask first if a gentleman could come."

People who had assistance with personal care said this was always provided in a dignified manner. "They are very kind and polite' always respectful." "They cover me with towels to keep warm and dignified." Staff were clear that they ensured people were comfortable and that care was always provided sensitively and considering peoples individual needs.

People had been involved in their care plans and were part of the regular review process. Senior staff carried out regular reviews where they gained feedback from people to ensure that they were happy with the care and support provided, this enabled staff to check whether there were any issues or if further help was required. When people's needs changed the service liaised with other health professionals to ensure their needs could be met.

People knew how to contact the service if they had any issues or concerns. There was an 'out of hour's number' and many people had access to 'lifeline' or similar emergency alert systems which they used in an emergency. Staff had an 'on call' number which they could use out of office hours if needed to contact a senior staff member for advice or support. Relatives told us if care staff had any concerns or if their loved one became unwell they were always contacted promptly. All staff were clear that in an emergency situation they would call the emergency services if required.

Care records were stored securely. Care staff were aware of the importance of maintaining confidentiality. A copy of daily records and care planning were kept in people's homes, with a copy of the care file and some further information regarding finances and LPOA kept in the office and on the computer system. Any sensitive information regarding people's health and care needs or for example safeguarding information was logged securely on the computer system. Staff demonstrated a good understanding of maintaining records and verbal information about people confidentially and were clear they would not discuss a

person's support needs with anyone not involved in providing care.

Good

Is the service responsive?

Our findings

People and relatives told us that the service was responsive to their needs. Care provided was person centred and had been devised after collaboration with the person and their next of kin (NoK) relatives or others involved in decisions regarding how their care was provided. The provider responded to people's needs on an individual basis and there was a continual process of assessment, planning and review of care.

People knew they had a care plan and that this was used to inform staff what care and support they needed. People told us, they could read the care plan if they needed to or discuss any changes with staff or the office.

Spot checks took place unannounced. Staff told us that a senior carer or management would attend a visit and observed that care was provided correctly. Spot checks also took place after visits to look at documentation and get feedback from people. People were asked if staff arrived and stayed the correct timescales and what care and support they had received. These were to ensure that people received their care safely and correctly and that staff were following procedures at all times.

There was a complaints procedure in place. Most people we spoke with told us they had never had cause to complain. However, they knew how to raise a concern if needed. Most told us that they would speak to one of the care staff or call the office directly. "The girls in the office are very good, very helpful." "I would explain the concern and they would sort it out, I haven't had cause to complain." We discussed with the acting manager that a copy of the complaints procedure could be added to the file in people's homes to ensure everyone was aware of the procedure. They informed us details regarding how to make a complaint would be added to the folders in people's homes to ensure everyone had access to this information. The acting manager informed us that there were currently no formal complaints being investigated. However, a clear process was in place to ensure all issues raised, no matter how minor were resolved and responded to promptly. One example given to us was that a person had telephoned the office to ask that a specific carer did not return. This was addressed and a note added to the computer to ensure they were not scheduled to visit this person. Administration staff told us this was not due to any specific issue but sometimes personalities did not match and people just preferred other carers to visit.

A hospital passport had been introduced in recent months. This contained relevant information about people. Their health related conditions, medicines, nutritional needs, likes, dislikes how they communicated and who was involved in their care. This meant that when people were admitted to hospital and were unable to tell people their preferences and care needs, hospital staff would be aware of their needs as the hospital passport would be taken with them.

Many people went out with family and kept themselves busy doing activities of their choice. People told us, "Staff are always happy to stop for a chat and a catch up." And, "I don't get many visitors so it's nice when they are here." People were encouraged to continue with hobbies and interests. Staff told us, "We talk about the news, their favourite programmes and their families. They like to tell you about things like parties and visits they have been on with family." Staff were aware that people who lived alone could become socially

isolated, some people attended groups and day centres, others preferred to stay at home. Staff told us they spent the time they had with them to talk and ensure they had everything they needed.

Good

Is the service well-led?

Our findings

Since the last inspection the registered manager had left and the service did not have a registered manager in post. Currently an acting manager was in day to charge. The acting manager had commenced the registration process with CQC to become the registered manager. A registered manager is a person who has registered with the 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 2008 and associated Regulations about how the service is run.'

Staff were clear about their roles and responsibilities and who they reported to. There was a clear chain of responsibility and leadership. Care staff were supported by team leaders. The team leaders were responsible for ensuring documentation was updated, and medicines were correct and up to date, they carried out spot checks on care staff and were also subject to checks themselves carried out by management team. Staff told us they had constant support from the office and administration staff and management. Staff were supported and encouraged to continually strive to improve. Telling us, "The support of the staff team is great. " And, "I do this job because I love it."

We received positive feedback regarding changes the acting manager had introduced since taking over the day to day management of Pentlow Community Care. People knew who was in charge and told us they knew they could telephone and speak to her or ask her to visit if they needed to speak to them. Staff felt that management was consistent and approachable. There was a clear system in place to improve communication between management and staff. This included daily office, team leader, and team meetings. These were minuted and showed a clear process of informing staff of any changes, improvements and information sharing amongst staff. The acting manager told us they had tried to improve communication, and made sure staff were aware they could be approached at any time if they needed to speak to a manager on a one to one basis or to encourage staff to raise general issues at meetings.

There was a carer of the month award. This was discussed at meetings and staff could nominate each other if they felt a staff member had done something that warranted recognition within the team, or if positive feedback had been received from a relative or person receiving care. Meetings took place regularly and carers meetings were scheduled over two days to help staff working different shifts to be able to attend. Minutes were available for people to read after the meeting to ensure they were aware of what had been discussed. Staff said that meetings were a good way of sharing ideas and finding out what was going on within the organisation.

There was a system in place to continually assess and monitor the quality of service provided. Audit information was used to continually improve and develop the service. This included auditing and reviews carried out by the acting manager regarding training levels, assessments, care reviews, medicines auditing, staffing levels, numbers of people employed, leaving and the reasons for this. Complaints, safeguarding's, accidents, incidents and falls were reviewed and analysed to identify any trends or themes. All information from auditing was transferred onto a 'shared drive' on the computer and could be accessed and reviewed by the organisation to ensure they had clear and consistent oversight of the agency and how it provided care.

People's feedback was sought at regular intervals and this information used to make changes and improvements if needed. Feedback was shared with staff. Staff told us that when they received positive feedback during meetings it made them feel proud.

Policies and procedures where available for staff to support practice. There was a whistle blowing policy and staff were aware of their responsibility to report any bad practice. The acting manager had a good understanding around 'duty of candour' and the importance of being open and transparent and involving people when things happened. The acting and operations manager told us that they were always keen to learn from incidents to improve future practice.

The acting manager was aware how and when to report and refer to other agencies, and we saw examples of when this had been done in the past.