Clarriots Homecare Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Clarriots Homecare on 29 February and 7 and 9 March 2016. This was an announced inspection. We do this to ensure staff are available to speak with us as most staff would be working away from the head office in people's homes. The service provides care and support for people in their own homes. At the time of the inspection Clarriots Homecare had contracts for 20 people.

People were of mixed age groups. Some people required more assistance either because of physical illnesses or because they were experiencing memory loss.

There was a registered manager in post. 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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

We found that there were sufficient staff to meet the needs of people using the service. The provider had taken into consideration the complex needs of each person. This was balanced with the travelling time between calls for staff to make a safe journey. However, people expressed they did not like different care workers attending to their needs, but realised this was often because of short term absenteeism and new staffing being recruited. A minority of calls had been missed which was being addressed by the registered manager to ensure people were safe.

We found that people's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan. People were involved in the planning of their care and had agreed to the care provided. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe.

The staff knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

The provider used safe systems when new staff were recruited. All new staff completed training before working on their own. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

People had been consulted about the development of the service and quality checks had been completed to ensure services met people's requirements.

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.

Checks were made to ensure the person's home was a safe place for staff to work in.

Sufficient staff were recruited to meet people's needs.

Staff knew how to recognise and report abuse.

Staff had been trained in the safe administration of medicines and recorded when they had supervised individuals.

Is the service effective?

Good

The service was effective.

Staff ensured people could live as independently as possible.

Staff received suitable training and support to enable them to do their job.

The key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Is the service caring?

Good

The service was caring.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Good

The service was responsive.

People's care was planned and reviewed on a regular basis with

them.

People knew how to make concerns known and felt assured anything raised would be investigated in a confidential manner.

Staff were able to identify people's needs and recorded the effectiveness of any treatment and care given.

Is the service well-led?

Good

The service was well-led.

People were able to speak with the registered manager at any time and voice their concerns or praise.

Audits were undertaken to measure the delivery of care, treatment and support given to people against current guidance.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

Clarriots Home 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 took place on 25 February 2016 and was announced. We also contacted people by telephone on 7 and 9 March 2016.

The inspection team consisted of an inspector.

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.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority who had previously commissioned services from the provider in order to obtain their view on the quality of care provided by the service. The provider currently only accepted privately funded clients.

During our inspection, we spoke with four people who used the service, two relatives, and four members of the care staff, a care co-ordinator, a member of the finance team, a member of the marketing team and the registered manager.

We looked at five people's care plan records and other records related to the running of and the quality of the service. Records included staff files, audit reports and questionnaires which had been sent to people who used the service.

Good

Is the service safe?

Our findings

People told us they felt safe when staff visited them. One person said, "Everyone is very good." Another person said, "They told me staff had been checked before they came to me."

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the senior staff would take the right action to safeguard people.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written in people's care plans. For example, when staff called on one person there had been a medical emergency. Staff had recorded what action they had taken at the time. Office staff had recorded how they ensured other people's calls were not late by mobilising staff cover. There was a process in place for reviewing accidents, incidents and safeguarding concerns on a monthly basis. This ensured any changes to practice by staff or changes which had to be made to people's care plans were passed on to staff. Staff told us they were informed through meetings and notices when actions needed to be revised.

To ensure people's safety was maintained a number of risk assessments were completed. For example, where people had a history of falling due to poor mobility, care plans were in place. Also risk assessments had been completed to see how well people could manoeuvre and the type of wheelchair and walking aid was in use. Each risk assessment was reviewed at least monthly or more frequently if people's needs changed.

People had plans in place to support them in case of an emergency. These gave details of people for staff to contact who were acting on a person's behalf or who the person told us they would like contacting.

People told us their needs were being met. However two people and a relative told us there had sometimes been a missed call. They told us that they realised this was due to short term absenteeism and the need to recruit more staff. A relative said, "My [named person] needs staff to attend on time, but I do tell the office when this has ever happened. They have apologised." One person said, "Staff are absolutely splendid." Another person said, "Yes, I'm happy they are dealing with my needs." People did not feel their care had been compromised if staff were late, but they had asked to always be kept informed. They told us missed calls were a very rare occurrence. The registered manager confirmed people were informed and this was written in their care plans. We saw this in the care plans we looked at.

Staff told us there were adequate staff on duty to meet people's needs. One member of staff said, "I'm on a nil hours contract but wanted to work a minimum amount of hours, which has been fulfilled." Another staff member said, "Sometimes the [named staff] don't realise we have to travel between calls and I don't like to be late. I've told them and it was corrected." As the majority of staff worked as lone workers a policy was in place describing and giving instruction on how they should be aware of risk when working. Staff were aware of the policy.

The manager showed us how they had calculated the numbers of staff required, which depended on people's needs and daily requirements. This was completed when a new contract commenced and then reviewed each month. This was written on each person's service agreement. We saw that this was checked alongside staff time sheets to ensure people were receiving the care as agreed.

We looked at three personal files of staff that had been recently recruited. Checks had been made to ensure they were safe to work with people who used the service. The files contained details of their initial interview and the job offered to them. People told us when staff prompted them to take their medicines. They said they ordered medicines themselves. We saw in the care plan of one person when staff had recorded when they had prompted a person to take their medicine and whether this had been successfully taken.

People told us when staff prompted them to take their medicines. They told us that they felt confident the staff were aware of what the medicines were, as they told them. People told us that they ordered medicines themselves. We saw in the care plan of one person when staff had recorded when they had prompted a person to take their medicine and whether this had been successfully taken.

Supporting people who required to have medicines was a minimal part of the work this provider undertook. Policies were in place to inform staff on how to support people and accurately document all processes undertaken. Staff who administered medicines had received training. Staff told us they had received this training and we saw this was recorded on the training records. Spot checks were undertaken by senior staff to observe they were administrating medicines safely.Reference material was available in the office.

Good

Is the service effective?

Our findings

People told us that they felt staff were sufficiently skilled and experienced to care and support them to have a good quality of life. One person said, "90% of staff are good and if they aren't I tell the office. Then something is done." Another person said, "They appear to know what they are doing." People told us the staff were matched to their needs and they could discuss their needs with them.

Two staff member told us about the introductory training process they had undertaken. This included assessments to test their skills in such tasks as manual handling and bathing people. This provided the skills they needed to meet people's needs safely. Details of the induction process were in the staff training files. The provider was embracing the new national Care Certificate which sets out common induction standards for social care staff and was building this into their induction programme.

Staff said they had completed training in topics such as basic food hygiene, first aid and manual handling. They told us training was always on offer and it helped them understand people's needs better. The training records supported their comments. This ensured the staff had the relevant training to meet people's specific needs at this time. There was a training room at the head office where some practical and other training took place. Equipment used for training had been checked for safe of use. Reference material on topics such as safeguarding adults and children, different types of illnesses and local support agencies were available.

Staff told us they could express their views during supervision and felt their opinions were valued. This ensured they had a voice in their workplace and could comment on the running of the home. We saw the supervision planner for 2015 and 2016. This gave the dates of when supervision and appraisal sessions had taken place. Staff confirmed these had occurred.

The Mental Capacity Act 2005 (MCA) legislation 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 capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff were knowledgeable about how to ensure that the rights of people who were not able to make or to communicate their own decisions were protected.

People told us staff asked for their consent before commencing any care and treatment. Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. .

People told us that the food was good and varied when staff had prepared meals. One person said, "They cater for my specific needs." A staff member gave details of all the meals they prepared for one person, and how they assisted that person to maintain a balanced diet to aid their health and well-being. Another staff member said, "I help [named person] to shop, which includes food shopping. I sometimes make suggestions about meals, but they are capable of making their own decisions.

The staff we talked with knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as a problem a person was having controlling their weight and diet because of a specific illness. We saw when staff asked for the assistance of the GP or visiting community nurse in sorting out people's dietary needs.

People told us staff tried to obtain the advice of other health and social care professionals when required. In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when people were unwell or needed the services of a community nurse to dress a wound.

Good

Is the service caring?

Our findings

People told us they liked the staff and they were confident the staff would give them good care. Staff were described as caring and kind. One person said, "Absolutely splendid." Another person said, "They are someone to talk too and I can with them all."

The people we spoke with told us they were supported to make choices and their preferences were listened to. One person said, "Yes, I'm happy with it all". A relative told us, "They came and asked [named person] how they liked things doing, which was nice." People told us they were given explanations when they needed them of the care and treatment staff were to perform. They said staff ensured this was explained in a way they understood. This included different ways of communicating with those who were sensory impaired' such as the deaf and those with impaired vision.

Staff told us they assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They said they also gave people the time to express their wishes and respected the decisions they made. They said time was built into their visit times to enable them to take time with people.

Staff told us how they responded when people said they had physical pain or discomfort. They said they had a care plan to read. If there was no record of what to do, if this was a new event, they had support from the office staff and details of the person's GP to gain advice. Relatives told us how they were kept informed of any different event which had occurred.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care were supported by staff and the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local advocacy service on display.

We saw in the care plans where staff had recorded when they had explained a new process or treatment. The person's wishes and specific requests had been recorded.

People told us they were treated with dignity and respect at all times. One person said, "I can't believe how caring they are these staff." A relative told us, "My [named person] tells me they are very respectful to them and I have found them polite and honest."

Good

Is the service responsive?

Our findings

People told us staff had talked with them about their specific needs. This was in reviews about their care, telephone calls and questionnaires. They told us they were aware staff kept notes about them and relatives informed us they also knew this. Paper and computer records were both in use. They told us they were involved in the care plan process. This was confirmed in the care notes we reviewed. Some of the language used in the care plans was not always person centred. The manager told us that work was in hand to make the care plans more person-centred.

The people we spoke with told us staff generally responded to their needs as quickly as they could. However, two people and a relative told us the responses depended on who the information was given too. One person said, "If you tell [named people] I don't know if they are as quick as passing on messages to the manager." Another person said, "The manager responds immediately, not so some of the other staff." They were happy for this information to be passed to the registered manager, which was completed. The manager told us they had not been informed of certain staff who had not responded and this was not seen in the complaints and concerns records. The manager told us they would address the issues with those staff immediately.

Staff knew the people they were caring for and supporting. They told us about people's likes and dislikes. For example, when they liked to get up in the morning and when they liked a shower or bath. This was confirmed in the care plans.

Staff told us they had time to look at care plans. However, they were generally only given brief details before a visit. They told us this meant they had to spend a little time on the first visit reading about the person's specific needs, which was part of their role on the first visit. They said they had time to do this. Staff told us because each visit was a minimum of one hour they had time to deliver the care and support to people and if more time was required this was negotiated with each person. We saw that care plans were reviewed at least monthly, with a full review taking place every six months.

Staff were encouraged to read the previous entries in each person's care plans to ensure they saw any messages which required to be passed on. Staff confirmed they did. Senior staff who were on an on-call rota passed information amongst themselves. Safe methods were in place by password protected access on the computer to people's care records when senior staff were on call.

People told us they were happy to make a complaint if necessary and felt their views would be respected. Each person knew how to make a complaint. Two people we spoke with had made concerns known to the registered manager since their admission, but not formal complaints. One was under investigation and the other had been resolved to the person's satisfaction. People knew all the staff names and told us they felt any complaint would be thoroughly investigated and the records confirmed this. The policy had been reviewed in August 2015.The complaints log detailed no formal complaints had been made since the last inspection.

Good

Is the service well-led?

Our findings

There was a registered manager in post. People told us they were well looked after, could express their views to the registered manager and felt their opinions were valued. One person said, "I say what I like, when I like but I am respected for it." A relative told us they had no problems in expressing views, which they felt were listened to by the registered manager.

People who received the services from the provider completed questionnaires about the quality of service being received. Some people told us they had not done this recently, but had been contacted by telephone. The provider clarified that questionniares had not been sent out in the last 12 months. One person said, "I like to express my view and getting it on paper is one way." The last questionnaire, in paper format was in March 2015, which the analysis showed had been positive. The care plans gave details of when people had been contacted in person or by telephone for their views. This was every 6 weeks. Testimonials were in each person's file every six months where they could state how they felt their needs had been met. A client's newsletter was produced every four weeks giving information about the company, local information and more light hearted articles. This was sent out electronically, posted or given out by staff.

Staff told us they worked well as a team even though they were usually lone workers. One staff member said, "We help each other when we can." Another person said, "I enjoy coming to work." Staff knew about the whistle blowing policy and told us they would not hesitate to use this if necessary.

Staff told us staff meetings were held. They said the meetings were used to keep them informed of the plans for the service and new ways of working. We saw the minutes of staff meetings for November 2015 and January 2016. Each meeting had a variety of topics which staff had discussed, such as, medicines, staffing and care plans. These ensured staffs was kept up to date with events.

The registered manager was seen negotiating care for people during our inspection. They talked with people who used the service and staff. They could immediately recall items of information about each person. The registered manager also completed unannounced spot checks on staff, to ensure they were attending their calls and could adequately give the care that was required. We saw this was recorded in the staff files.

There was evidence to show the home manager had completed audits to test the quality of the service. These included medicines, care plans, environmental checks in people's homes and equipment. Staff were able to tell us which audits they were responsible for completing. Where actions were required these had been clearly identified and signed when completed. Accidents and incidents were analysed monthly to ensure people were not at risk and staff told us that they amended people's care plans when necessary. Any changes of practice required by staff were highlighted in staff meetings so staff were aware if lessons had to be learnt from incidents.

Notice boards at the location kept staff informed of new information about the provider and other events. This included staff fund raising events, training sessions on offer and details of the Care Quality Commission access points. This team and other staff had recently been involved in local events to promote care at home

for those with memory loss and mental health problems and were working with local charities.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The manager understood their responsibilities and knew of other resources they could use for advice, such as the internet.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.