Carlton Home Care Ltd

Carlton Home Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 4 and 5 September 2018 and was announced. At our last inspection in March 2018, we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to Regulation 12; safe management of medicines, Regulation 11; need for consent, Regulation 9; person centred care, Regulation 17; good governance and Regulation 13; safeguarding service users from abuse and improper treatment. We met with the provider and asked them to complete an action plan to tell us what they would do and by when to improve the service. At this inspection we found sufficient improvements had been made to meet the relevant requirements of the Regulations. This is the third consecutive time the service has been rated Requires Improvement.

Carlton Home Care is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults. At the time of our inspection there were 58 people using the service.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CCQ) 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.

Improvements had been made to the management of medicines and people generally received medicines as prescribed. However, further improvements were required to the administration of time specific medicines and to ensure creams were administered as prescribed.

Staff were being recruited safely and there were enough staff to take care of people. However, some people told us staff did not always arrive on time and stay for the allotted length of time. Staff were receiving appropriate training and they told us the training was good and relevant to their role. Staff were supported by the registered manager and were receiving formal supervision where they could discuss their ongoing development needs. However, the registered manager recognised spot checks on staff competency needed to be embedded.

People who used the service and their relatives told us staff were helpful, attentive and caring. People told us most staff treated them with respect and compassion.

People told us they felt safe in the company of staff. Systems were in place to record and report concerns about any suspected abuse. Staff had received safeguarding training and knew how to recognise and report signs of abuse. A range of assessments were in place to mitigate any risks to people's health and welfare. Accidents and incidents were documented with clear actions taken as a result.

Care plans were mostly up to date, person centred and detailed what care and support people wanted and needed.

From our discussions with people, relatives and staff and from reviewing care records, we concluded people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The service liaised with a range of healthcare professionals to ensure people's healthcare needs were met.

Staff knew about people's dietary needs and preferences and these were documented in people's care records.

A complaints procedure was in place. Complaints were taken seriously, investigated, and the complainant informed of actions taken as a result.

People, relatives and most staff spoke highly of the registered manager who said they were approachable and supportive. The provider had systems in place to monitor the quality of care provided and where issues were identified they took action to make improvements. However further work was required to embed these improvements and ensure all staff who completed audits did so effectively.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff were recruited safely. There were enough staff to provide people with the care and support they needed. However, staff did not always arrive in a timely manner or stay for the allotted length of time.

Staff understood how to keep people safe and where risks had been identified, action had been taken to mitigate those risks.

Medicines were mostly managed safely although further improvements were required to ensure time specific medicines were administered safely and all creams administered as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were trained and supported to ensure they had the skills and knowledge to meet people's needs. Regular spot checks to ensure staff were providing safe and effective care needed to be embedded.

The legal requirements relating to the Mental Capacity Act (2005) were being met although some people's support plans needed signing to show they had been involved in decisions about their care and support.

Is the service caring?

Good

The service was caring.

People using the services told us they liked the staff and found them attentive and kind. Staff knew people well and people told us staff treated them with kindness and patience.

People's privacy and dignity was respected and maintained.

Is the service responsive?

Good

The service was responsive.

People's care records were easy to follow, mostly up to date and reviewed regularly.

A complaints procedure was in place and people told us they felt able to raise any concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A registered manager was in place who provided leadership and support.

Quality assurance systems were in place to assess, monitor and improve the quality of the service. These had improved since the last inspection although further improvements were needed to ensure these identified all required actions.

The management team were keen to continue to make improvements to the service.

Carlton Home Care

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 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 4 and 4 September 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The membership of the inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert used on this occasion had experience of caring for older people and dementia care.

On 4 September 2018 the expert-by-experience spoke on the telephone with people who used the service and/or their relatives and one adult social care inspector interviewed care staff on the telephone. Two adult social care inspectors visited the office location on 5 September 2018 to see the registered manager and office staff and to review care records and policies and procedures.

Before the inspection we reviewed the information we held about the service. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams. We used the feedback received to inform our inspection.

We usually ask the provider to complete a Provider Information Return (PIR). The PIR is a document we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we had not requested a PIR.

We spoke on the telephone with five people who used the service, three relatives and six care staff on 4 September 2018. On 5 September 2018, we spoke with the registered manager, the care co-ordinator, the governance lead and one person's relative who was visiting the office. We also spent time looking at records,

which included five people's care records, four staff recruitment files and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in March 2018, we found the service was in breach of Regulation 12; safe care and treatment – safe management of medicines and Regulation 13; safeguarding service users from abuse and improper treatment. At this inspection, we found sufficient improvements had been made and the service was no longer in breach of the Regulations.

Each person receiving medicine support had a medicine profile setting out the medicines they were prescribed, their purpose and any side effects. Medicines administration records (MARs) were returned to the office so these could be checked in line with the provider's policies and procedures. We looked at a sample of MARs and saw these were well completed which showed people received their medicines as prescribed. However, the registered manager acknowledged further improvements were required, such as ensuring sufficient gaps were always maintained between time specific medicines such as Paracetamol and ensuring creams were applied as prescribed.

People told us they received their medicines as prescribed although many people told us they or their relatives managed their own medicines. One person told us, "(I have) tablets and cream for my bottom. I have all my tablets in a weekday box and I do all that myself. I can cope with that. The carers put all the cream on for me." Another person told us, "Yes, but can't always be exact, as (I'm) meant to take some tablets every four hours, but they can't be here exactly on time and if they aren't here exactly at the time, I have a pill box with them in, so my husband gives me them. We have an agreement with the carers to do that and we tell the carer when she arrives."

National Institute for Health and Care Excellence (NICE) guidance on managing medicines in the community states that an annual review of staff skill and knowledge must take place. At the time of the inspection, annual staff competency assessments for safe management of medicines had not been undertaken. We spoke with the registered manager who told us they would address this.

People were kept safe from abuse and improper treatment and told us they felt safe in the presence of staff. One person told us, "Not only do we feel safe, but we trust them anywhere in the house. All the girls are very good." Another person commented, "They use the key safe and open the door and I can hear them; they come in and say 'morning, can we help you, what needs doing first?'."

Staff had completed safeguarding training and said they would not hesitate to report concerns to a senior member of staff, the registered manager or the safeguarding team. The registered manager understood the referral process and had made appropriate referrals to the safeguarding team when this had been needed. This meant staff understood and followed the correct processes to keep people safe.

The service looked after one person's money for shopping purposes. Records of monies held were kept and receipts for any purchases were obtained. The registered manager acknowledged they had not audited these regularly to ensure the person was safe from possible financial abuse. However, during our inspection they put plans in place to increase the person's social inclusion time and were liaising with the person and

their social worker to implement this. This meant staff would be able to assist the person to go out and do their own shopping which would increase their independence and ensure the person remained in control of their own finances.

Accidents and incidents were recorded and analysed to see if any themes or trends could be identified. Records showed what action had been taken following any accident or incident to reduce or eliminate the likelihood of it happening again.

Assessments were mostly in place to mitigate risks to people's health and safety which included those for moving and handling, internal and exterior environment and the use of the bath/shower. These provided information to staff on how to deliver care safely. We saw some updated risk assessments were still in the service office, awaiting being taken out to people's properties. However, the registered manager told us staff had access to these on their mobile devices. Where people had moving and handling care needs we saw there were detailed instructions for staff to follow. For example, these included how to support the person and the type and size of sling to use when hoisting equipment was used.

Records showed safe recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. The required checks took place on new staff including identity checks, obtaining references and completing a Disclosure and Baring Service (DBS) check. Staff confirmed these checks had been completed before they commenced their role at the service.

There were enough staff employed to care for people safely. Most staff we spoke with told us there were enough staff to ensure people's needs were met. Staff said they had worked together to ensure visits were maintained over the last few weeks despite annual leave and sickness. The registered manager told us they turned down care packages if they felt unable to fulfil these due to not having sufficient staff coverage. They told us they had a rolling recruitment process in place to enable them to ensure they had adequate cover as well as to develop new business.

People who used the service and relatives told us there were enough staff and staff completed all tasks during the visit. However, some people told us staff did not always come at the allotted time and they were not informed if staff were going to be late. Comments included, "Punctuality gets me - they came 10:20 a.m. again just this last week and it should be 9:00 to 9:30 a.m.", "They are supposed to come to visit once a day in the morning for half an hour at 7:10 a.m., but sometimes they come at 7:00 a.m. and other times at 10:30 a.m., like yesterday. I can't be doing with all that. I have a life to live and I like to be able to go out and because they arrive too late, I have had to cancel my visitors taking me out when they come to collect me, as I'm not ready, which is not very good. I had to sit one morning with a really dirty nappy on until really late when they arrived, and I tried to do it myself, as otherwise, I sit there wet through" and "Yes, they get here late sometimes and sometimes early. No one rings me to say they'll be late. I don't ring the office to tell them the carer is late." Some people also commented about staff not remaining for the full length of the allocated time. One person told us, "If I have paid for someone for half an hour, why shouldn't I be able to have a little chat to them with they have finished what they are doing before the half hour is up, but they don't stay. I look forward to seeing them. 11:00 a.m. is the latest they have arrived. It is a ridiculous time and I have told them to never come again that late. I have spoken to the office about it, but it still happens." We spoke with the registered manager who was aware of some of the concerns raised and agreed this was not acceptable practice. We saw punctuality and communication had been highlighted by the registered manager and governance lead from the latest telephone satisfaction survey and this was an agenda item for the next staff meeting.

Personal emergency evacuation plans (PEEPS) were in place and these were up to date and relevant. An

emergency contingency policy was in place and senior staff took turns to be 'on-call' out of hours for staff to contact them should an emergency situation arise.

We saw staff had access to personal protective equipment, such as gloves and aprons and people told us staff were using these appropriately.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in January 2018, the service was not able to evidence they had seen documentation that showed people had legal powers to act and consent on people's behalf, such as lasting power of attorney (LPA). This meant the service was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, we saw most people had documentation in place where this was required and the service was no longer in breach of the Regulation.

One person had access to an advocate to speak on their behalf and we saw the advocate's contact information was contained in the person's care records. However, one person's relative had consented for care and support on their behalf but there was no evidence in the care records that a best interest meetings had taken place or if the relative had the authority to consent on the person's behalf. The registered manager told us they would investigate this immediately. From speaking with them, we concluded this was an isolated oversight which would be addressed. We also found some people's support plans needed signing to show they had been involved in decisions about their care and support.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. In the case of domiciliary care agencies, applications to authorise a deprivation of liberty must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA. The registered manager told us they had not needed to make any applications to the Court of Protection. From our discussions we concluded the registered manager understood their legal responsibilities under the Act. People told us staff asked their consent before care and support was provided.

People's care needs were assessed, and appropriate plans of care put in place. The service worked with a range of health professionals to develop care plans that adhered to recognised guidance.

People who used the service told us they thought staff were well trained and knew what they were doing. One person commented, "Oh yes certainly, they know everything they are doing and know what they are talking about."

A training matrix was in place which indicated what training staff had completed and when refresher training was required. Staff received training and updates in a range of subjects including safeguarding, moving and handling, homecare, Mental Capacity Act (MCA), dementia, food hygiene and infection control. We looked at staff training records and saw training was up to date or booked and records indicated when training was due. Training was provided using a mixture of on-line training and face to face sessions held at

the training rooms at the provider's head office or at another of the provider's registered locations. New staff completed induction training and staff new to care were enrolled on the Care Certificate. The Care Certificate is a set of standards designed to equip social care and health workers with the knowledge and skills they need to provide safe, compassionate care.

Staff were provided with regular supervision and annual appraisal which gave them the opportunity to discuss their work role, any issues and their professional development. Staff we spoke with told us they felt supported and said they could go to the registered manager at any time for advice or support. Staff also were subject to some spot checks of their practice. This included checking they arrived at the person's home on time, stayed for the correct amount of time, completed the required tasks and treated the person with dignity and respect. This provided a support mechanism and allowed the service to monitor staff performance. However, the registered manager agreed these needed to be implemented on a more regular basis in line with good practice guidelines.

The service liaised with a range of health professionals including GP's, physiotherapists, social workers, occupational therapists and district nurses to ensure people's health and social care needs were met. Where staff were concerned or had noted a change in people's health we saw they had made referrals to health professionals. For example, one person told us, "Yes, they said the other day that they were concerned about my legs and they spoke to someone to have a look at it." This contact was recorded within electronic notes on the service's computer system. Staff had a good rapport with health care professionals. For example, one staff member had worked with physiotherapists to learn the best way to assist a person they supported to mobilise and to share best practice.

At the time of our inspection, no-one who used the service had been assessed as at nutritional risk. Most people told us they or their families provided their food. However, when the service was responsible for people's food, we saw information about their likes and dislikes was contained in their care records and daily notes indicated staff followed this guidance. We saw in daily notes that staff ensured people had access to snacks and drinks before they left the call.

Good

Is the service caring?

Our findings

People who used the service told us they were generally happy with the care they received from Carlton Home Care and regular staff were kind and knew them well. Comments included, "Oh yes, without doubt", "Yes, I am. I can't grumble - only when they are late coming to help me get up in the morning" and "Yes, they are all very cheerful and engage in conversation."

Care files contained information about people's life histories, interests and hobbies. Staff we spoke with knew and were able to give examples about the care and support they provided to people. People told us most staff knew their individual needs, particularly regular staff. Comments included, "Yes they do. For example, how I like my shoes put on and how I like them tied" and "Yes, they do; they do anything I want. When there's a new girl coming, I have to tell them what I need them to do and they do it."

Staff told us they took time to chat with people during the calls. Some staff said they made time to sit with people after tasks had been completed to spend quality time with people, although people told us some staff did this and other staff did not. One person told us, "Yes, they are all very cheerful and engage in conversation." Most people said they were introduced to new staff but had not always received consistent staff recently. The registered manager told us they had struggled to maintain consistent staff on people's calls over the last few weeks due to holidays and staff sickness but always tried to ensure this took place.

People receiving support from the service told us staff were respectful and treated them with dignity. They told us staff always respected their privacy when providing personal care. One person commented, "Yes... They always say, 'what do you want, what can I do' and I told them to call me by my first name. They are all very respectful and not one that is nasty to me; I couldn't say anything against them, especially [care staff name]; she's lovely." Another person told us staff treated them with respect and said, "All the time. Well, we talk and we have banter; I know whose leg I can pull and those I can't, but they are all good and efficient."

People who used the service and relatives had been involved in developing their care plans and some people said they had been involved with reviewing care and support when their care needs changed. We saw one person's relative called into the service's office during our inspection to review the support package.

The registered manager was aware of their responsibility to support people to access advocacy services if they required the support of an advocate. An advocate is a person who can support and speak up for a person who does not have any family members or friends who can act on their behalf.

Staff encouraged people who used the service to be as independent as possible. For example, one person's relative explained how staff encouraged their loved one to walk around their living room chair to help increase their mobility. We saw the registered manager was working with another person and their social worker to increase their social inclusion and encourage them to shop and take control of their personal finances.

We looked at whether the service complied with the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Staff had received equality and diversity training. Our review of records and discussion with the registered manager, staff, people and relatives showed us the service was pro-active in promoting people's rights.

Good

Is the service responsive?

Our findings

At our previous inspection in January 2018, we found care plans did not always reflect people's needs and the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found sufficient improvements had been made and the service was no longer in breach of the Regulation.

People's needs were assessed, and care plans formulated to meet these needs. These included detailed information about the care and support staff were to provide at each visit. We saw care records focussed on achievable goals for people, such as being able to remain in their own home, or to maintain contact with the community. Staff were able to describe the care they provided at calls which reflected the information contained in people's care records.

Care plans were person centred and contained information about people's preferences and how they wanted their care to be delivered. For example, one person's plan said, '[Person] likes to have their door open at night so they can shout [for person's relative] if needed' and '[Person] usually wears a skirt with tights, blouse or a t-shirt with a cardigan.'

Care records were reviewed with changes generally made where required. We saw people were asked if they were satisfied with the care and support they received. People who used the service and relatives told us they had been involved in the care planning and review process. However, one person's care record did not reflect the increased support they were receiving following a recent hospital admission. We spoke with the registered manager who showed us the updated information had been put on the service's computer system, which staff had access to, and needed to be printed out to put in the 'hard copy' of their care records.

Care records contained risk assessments relating to activities of daily living such as mobility, eating and drinking, continence and personal care. The risk assessments and care plans were reviewed regularly and where an issue had been identified, action had been taken to address and minimise any identified risk. For example, we saw some people had specialist mobility products in place to reduce the risks of them falling.

The provider had appropriate systems in place to support people at the end of their life to have a comfortable, dignified and pain-free death. However, at the time of our inspection, the service was not providing anyone with end of life care.

Complaints were taken seriously and investigated, discussed with the complainant and actions taken. Six complaints had been registered since our last inspection. We saw a complaints log was kept at the front of the complaints file with details and actions, which the registered manager and the provider's governance lead monitored for trends and looked at lessons learned as a result. Most people told us they knew how to raise a complaint but had not needed to do so, or the management team had sorted out any concerns they had raised. Comments included, "Yes, I would speak to the manager in the office. I haven't needed to make a complaint other than about the carers visiting too early in the mornings, which was all resolved" and "Yes, I

would be happy to make a complaint if I needed to, but no, I've never made a complaint." We saw 38 compliments about the care and support provided had been noted since the start of 2018, including compliments received from district nurses and social workers about staff and the care they provided.

We looked at what the service was doing to meet the Accessible Information Standard (2016). The Accessible Information Standard requires staff to identify record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. An accessible information policy was in place. We saw people's communication needs were assessed and support plans put in place to help staff meet their needs. For example, one person had reduced eyesight and information about relevant contact and service information had been produced for them in large print. They told us this had helped them considerably.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in January 2018 we found the service was in breach of Regulation 17, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was regarding the assessment, monitoring and improvement of the quality and safety of the services provided in carrying out the regulated services. At this inspection, although we found some improvements had been made and the service was no longer in breach of the Regulation, further improvements were required.

There was a range of audits in place which included medication, care records and call record documents which included call times. These were audited on a regular basis and some actions taken as a result. However, some concerns we found around areas such as monitoring of creams, time specific medicines and call times had not been identified during formal audit processes. The registered manager was aware of concerns raised about call times through the recent telephone survey. We saw this had been highlighted to discuss at the next staff meeting and staff had been subject to supervision and disciplinary procedures in the past around this. The registered manager also told us they were organising further training and support for some senior staff responsible for auditing care records and medicines administration records to ensure they were able to better identify and act on issues found. We saw the provider also audited and analysed a range of areas including care records, risk assessments, accidents/incidents and complaints. An action plan had been developed with the registered manager as a result to drive service improvements.

There was a registered manager in post who provided leadership and support. People told us they knew who the registered manager was and were happy to approach them if they had any concerns. One person's relative told us, "Yes, [registered manager's name]. She is very friendly, very helpful and a very nice person. She sorts everything out on time. Since she took over, things have been going very well."

Most staff told us they would be able to approach the registered manager with any concerns. One staff member told us the registered manager had an 'open door' policy and they would ask for any guidance if required.

We found the management team open and committed to make a genuine difference to the lives of people living at the service and delivering improvements to the service. This gave us assurance that the areas of concern we identified would be taken seriously and addressed. We saw there was a clear vision about delivering optimum care, based around empowering people and achieving good outcomes for people receiving the service. The registered manager and governance lead told us they were aware improvements were still required in some areas but we saw significant improvements had been made since our last inspection. The registered manager told us they received good support from the provider and staff.

People's opinions about the service and any required improvements were sought through quarterly satisfaction surveys. We saw these were reviewed, concerns discussed with people and actions taken as a result. This showed people's views about the service were sought and acted upon. One person told us, "Oh yes, we get them fairly regularly and we fill them out and they get sent back."

Regular staff meetings were held to highlight issues, discuss concerns and share best practice. Staff told us they felt able to speak up at these meetings and found them useful. Staff satisfaction surveys were completed on a quality basis. We looked at the responses from the latest staff survey which had just been completed. This had been analysed and collated and showed positive responses.

Most staff we spoke with told us they were happy in their role and would recommend the service as a place from which to receive care and a place to work. Most people told us they were satisfied with the care and support they received, apart from some concerns about call times, and would recommend Carlton Home Care.

The registered manager told us they attended provider meetings held at the local authority as well as the provider's own manager meetings to discuss and share best practice. The service also worked in partnership with a number of agencies and specialist services to offer optimum support to people. The registered manager also told us they ensured they kept up to date with best practice through on-line portals such as Care Quality Commission (CQC) and the National Institute for Care Excellence (NICE).

The registered manager was aware of and had complied with their obligation to submit notifications to the CQC and to display their up to date inspection rating.