West Anglia Crossroads Caring for Carers

Carers Trust Cambridgeshire

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

Carers Trust Cambridgeshire is registered to provide personal care for people who live at home. The people receiving the care live with a range of physical and mental health conditions. At the time of our inspection there were 74 people using the agency.

This comprehensive inspection took place on 14 March 2016 and was announced.

A registered manager was in post at the time of the inspection. They had been registered since 22June 2014. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the agency. 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 agency is run.

People were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were supported to take their medicines as prescribed.

People were supported to eat and drink sufficient amounts of food and drink. They were also supported to access health care services and their individual health needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 (MCA 2005) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. However, they had no arrangements in place to assess people's mental capacity; people's mental capacity was assessed by agencies who were responsible for funding their care. Nevertheless, the assessments were not available and we were not fully confident that any restrictions were based on justified reasons.

People were looked after by staff who were trained and supported to do their job.

People were treated by kind and respectful staff who they liked. They and their relatives were given opportunities to be involved in the review of people's individual care plans.

People were supported to reduce the risk of social isolation; they were helped to go shopping or take part in recreational activities that were important to them. Care was provided based on people's individual needs. There was a process in place so that people's concerns and complaints were listened to and these were acted upon.

The registered manager was supported by a team of office based staff, management staff, care staff and by the provider. Staff were supported and managed to look after people in a safe way. Staff, people and their

relatives were able to make suggestions and actions were taken as a result. Quality monitoring procedures were in place and action had been taken where improvements were identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were looked after by sufficient numbers of suitable staff.

Risks were assessed and measures were taken to manage people's risks.

People were helped to manage their medicines by staff who were trained and assessed to be competent to do so.

Is the service effective?

Good

The service was effective.

There was a lack of assessments of people's capacity to demonstrate that the provider was acting in accordance with the requirements of the Mental Capacity Act. However, staff were aware of protecting people's rights.

People were looked after by staff who were trained and supported to do their job.

People's nutritional, physical and mental health was maintained.

Is the service caring?

Good

The service was caring.

People were enabled to be involved in making decisions about their care.

Staff supported people to maintain their dignity and independence.

People were looked after by kind and caring members of staff.

Is the service responsive?

Good

The service was responsive.

People's individual needs were met.

People were enabled to take part in a range of activities that were important to them.

There was a complaints procedure in place and the provider responded to people's concerns or complaints.

Is the service well-led?

Good

The service was well-led.

Staff were managed in a way to ensure that they provided people with a safe standard of care.

People and staff were enabled to make suggestions to improve the quality of the care provided.

Quality assurance systems were in place to monitor and review the standard and safety of people's care.

Carers Trust Cambridgeshire

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 was carried out on 14 March 2016. The provider was given 72 hours' notice because the agency provides a domiciliary care service and we needed to be sure that someone would be in. The inspection was carried out by one inspector.

Before the inspection, we looked at all of the information that we had about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Also before the inspection we received 19 out of 50 completed questionnaires from people who used the agency and 27 out of 80 completed questionnaires from members of staff. Furthermore, we received four out of 50 questionnaires that we had sent to families and friends and 11 out of 100 questionnaires were returned to us from community professionals. We made contact with a local contracts manager, community professional and community care manager to gain their views about the service and aid our planning of the inspection.

During the inspection we visited the agency's office where we spoke with the registered manager; a human resources' officer; a care manager and four members of care staff. We also spoke with four people who use the agency and four relatives via the telephone.

We looked at five people's care records and records in relation to the management of the agency and staff.

Good

Is the service safe?

Our findings

People and their relatives said that they felt safe because staff treated them well and felt protected from the risk of harm. One relative told us that the way they family members were looked after made them feel very safe. They expanded on this and said that care staff adhered to the care plan which made their relative feel safe from being looked after in a structured way. They said, "It [the care] is quite precise and this helps him have confidence in staff and makes him feel safe." One person said that, because they had the same staff look after them, this had helped them feel safe. They said, "It does help if I know who's coming."

There were procedures in place to minimise the risks of harm to people. This included the training of staff in protecting people from such risks. Members of care staff were able to describe the types of harm and the actions they would take, which included reporting the incident to the police and local authority. Staff were also aware of the signs of symptoms that people can show if they were being harmed. One member of care staff said, "The person could show withdrawal. Or have marks on their body." Another member of care staff said, "They [person] may have unexplained bruises; they may seem jumpy or scared; or losing weight."

The provider had submitted notifications that demonstrated the appropriate actions they had taken to minimise the risk of harm to people. In addition to this, there was a staff disciplinary procedure in place which would be carried out in the event that individual members of staff failed to provide people with safe care.

We asked people, their relatives and the staff whether they thought there were enough care staff to meet people's needs. We were told that there was always enough care staff who arrived on time and stayed the allocated time. One person said, "[Care] staff are punctual. And are regular staff." One relative said that the care staff were "Spot on [time].They're never late." Another relative said, "There's a good percentage of regular staff and always they [provider] gets someone [another member of care staff] to cover staff sickness or holidays." Members of care staff told us that there was always enough staff and measures were in place to cover staff absences or vacancies. One member of care staff said, "Just after Christmas, some staff had left. So we had to cover other work. But it was manageable." Another member of care staff told us that they covered staff absences when they were requested to do so. One care manager told us that staffing numbers were determined based on the initial assessment of a prospective person's needs.

Members of care staff told us that they had the time to provide people with the care that they needed, which included sitting down and talking with the person. This was because there was enough staff, and therefore, time, to be able to do this. One member of care staff said, "I love the fact that you have the time to spend quality time with people [who used the agency]." Staff members also told us that there was sufficient staff to provide two staff members to work together. This included when a person needed assistance with their moving and handling needs by the means of a hoist operated by two staff members.

Recruitment systems were in place to ensure that all checks were carried out before prospective employees were deemed suitable to do the job that they had applied for. Members of staff described their experience of when they were applying and recruited to the job. One member of care staff said, "I had a CRB [Criminal

Record Bureau] check. I filled in an application form; there were two or three written references and I had to attend an interview." The human resources' officer said, "When they [prospective employee] come in for an interview, they have to provide ID [identity] documents and proof of their eligibility to work. They will have completed an application form or C.V. [curriculum vita]. We do an employment history check at interview. Then we ask what happened during the gaps in employment. There is a DBS [Disclosure and Barring Service which has replaced the CRB] and three satisfactory written references." They told us that all satisfactory checks were in place before newly recruited staff were allowed to look after people.

Risk assessments were carried out and measures were in place to manage the risks. These included risks to the security of people's homes. Care staff were aware of how to manage these risks. One person said, "I have a key safe and they [care staff] always put the key back in the safe." One member of care staff said, "When I leave someone's home, I make sure the doors are locked and 'ruffle' up the door key code. And make sure the key box [safe] is locked." Another member of care staff also told us, "Risk assessments are to minimise the risks and hazards and to enable people to do things in a safe way." They gave an example of managing a person's risk of using exercise equipment; they described the moving and handling techniques used that were safe for both the person and members of care staff.

Most of the people told us that they were independent in managing their own medicines. Relatives also confirmed that they helped their family member with their medicines. One relative said that they were "very clear" about their responsibilities in managing their family member's medicines. When people were supported to manage their prescribed medicines, they or their relatives said that they were satisfied with how this was done. One relative told us that staff followed their family member's care plan in relation to management of medicines. They told us that staff "encouraged and prompted" their family member to take their medicines. One member of care staff said, "I encourage a person to take their medicines. I would put them one at a time into their hand and encourage them to put them in their mouth. And take a drink of water." They told us that they checked that the person had safely swallowed their medicines. Completed medicines administration records [MARs] demonstrated that people were supported to take their medicines as prescribed.

When people needed assistance with taking their prescribed medicines, staff were trained and assessed to be competent in carrying out this part of their role. One member of care staff said, "I've just done my medication competency [assessment] again." Training and competency records showed that staff were trained and had been assessed to be safe in handling people's medicines.

One care manager told us that they audited MARs and said, "I'm looking for any gaps or anomalies. Then I investigate to establish why the gaps were there in the first place. A training need may be identified of staff have not correctly completed the MARs. Or evidence that care was not provided on that day to justify the gap."

Good

Is the service effective?

Our findings

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. At the time of our inspection most, but not all, of the people who used the agency had mental capacity to make decisions about their support.

The registered manager told us that people's mental capacity assessments were carried out by individual agencies, who were responsible for the payment of people's care; this included local authorities and NHS continuing care. However, the registered manager told that that there was no system in place for the provider to carry out its own mental capacity assessment. Care staff provided an example of a person who was living with dementia and the care that they received. We were told that the person was unable to maintain their nutritional health unless by artificial feeding methods. The registered manager told us that another person was looked after in bed all of the time. However, there was no documentation available to demonstrate that these care practices were carried out in the person's best interest or had been authorised by designated authorities. We, therefore, could not be sure that people's rights were being protected in accordance with the MCA.

Members of staff told us that they had training in the application of the MCA and had 'cue' cards to remind them about this. Care staff members demonstrated their knowledge in the application of the MCA. One member of care staff said, "A person always is assumed to have capacity unless proven otherwise. If a person wants to make a decision that seems unwise, it's their right to make the decision. If a best interest decision is to be made [on behalf of the person] you would have an advocate, a power of attorney and taking the view of the person [as part of the best interest decision making process]."

Staff surveyed told us that they enjoyed their job. They also said that they had the training although only 83% said that they had attended induction training before they looked after people. On the day of our visit newly appointed staff were attending induction training. The registered manager told us that this was a three-week process which incorporated the provider's mandatory training with the local authority's training. The induction training also included 'shadowing' training. One member of care staff said, "The induction training was mandatory training in safeguarding people at risk; moving and handling; fire safety and food handling. We had to 'shadow' a certain amount of hours when I went out with a more experienced member of staff. I observed what they were doing. Then I was observed and signed off by my manager before I could go out and work on my own."

A relative told us that care staff knew how to assist their family member with their nutritional needs by means of artificial means. Staff said that they had attended a range of training which they found beneficial. One member of care staff said that the dementia awareness training "had made me see things differently."

Another member of care staff, who had also attended the dementia awareness training, said, "You would go along with the person's own reality. You don't force your own reality on them. You try and understand their reality."

Not all of the staff said in their completed surveys said that they received regular supervision and appraisals to help with their training and development needs. However, we found from speaking with other staff that they felt supported to do their job and received one-to-one supervision. One member of care staff said, "I'm asked how I am finding my job." Another member of care staff said, "It's a good company to work for. You feel appreciated and valued."

Staff said that they found that the staff meetings provided opportunities for colleagues to support each other and discuss work-related topics. 'Spot checks' also provided another means of supervising staff. Care staff told us that the spot checks were unannounced and carried out by a more senior member of staff. One member of care staff said, "When somebody [senior staff member] comes out, they basically check you are doing your job. They check you are washing your hands, wearing your ID and giving people respect." They told us that they received feedback regarding how they were working and any changes that were to be made, if needed. They said that their feedback was "positive" and that they were working to the provider's expected standards.

Some people who used the agency needed assistance with maintaining their nutritional health. Assessments were in place and people's weights were monitored; the frequency of this was based on their individual nutritional assessment. Evidence suggested people were provided with sufficient amounts to eat and drink. Members of care staff were aware of the signs of when a person was not taking sufficient amounts of food and drink. One member of care staff told us one of the signs would be the presence of uneaten food or drinks not taken. Another member of staff told us what action they would take if a person was not eating enough. They said, "I encourage people to eat more if they don't eat." Members of care staff were aware of the physical signs of undernourishment and dehydration. These included dryness of a person's mouth and unintentional weight loss.

People told us that care staff offered them a choice of what they would like to eat. One person said, "I have frozen meals [to be cooked by staff]. I have a choice and variety and I tell them [care staff] what I want. They [care staff] do [prepare] whatever I want for my tea and drink in my [vacuum] flask. They leave me with fruit juice and water by my side." Members of care staff told us about how they offered people choices of what they would like to eat. One member of care staff said, "I have asked people what they like and give them a choice of what to eat and drink. I would give them a choice of a ready meal, beans on toast or soup, for example."

One person said, "I think I have improved my life having the support [from the agency staff]." Another person said that the care they received was "fantastic" and this had enabled them to keep well and living at home.

Members of staff from a GP practice told us that they were very satisfied with how people were supported to manage their health conditions. Members of care staff gave examples of what action they had taken when they had found a person had fallen or become unwell. One member of care staff said, "I have had first aid training and I have called 999 in an emergency [for a person who was not well]." They described the correct action they had taken whilst waiting for emergency health care professionals to arrive. This included checking vital signs of the person's conscious level, breathing and circulation.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring and often had the same care staff to look after them. One person said, "Quite often I get the same regular carers. They check to see if I want anything else doing [before they leave]." Another person said, "Because I have regular [care] staff, they have got to know me very well. The [care] staff are kind and respectful. If I ask them to do something, they will do it."

A community care manager told us that because people were looked after by a consistent team of care staff, this had helped them develop a good "rapport" with people they looked after. One relative said, "I would say that staff do get to know [names of family members] very well. I hear them [care staff]. And they do communicate with them at their level." Another relative said, "The [care] staff are first class. They respect [name of family member's] privacy and they are always checking and asking if [name of family member] is okay."

People told us that if they preferred to have their care provided by a female or male staff member only, this was respected. One person said, "I prefer women [female care staff] and they [provider] do respect that." We received positive comments made by a local contracts manager who told us that staff valued and respected people's right to privacy and dignity. Members of care staff were aware of maintaining people's privacy and dignity. They described how they assisted people with personal care in private and keeping them covered up during these times.

People told us that staff enabled them to maintain their level of independence and members of care staff told us that this was one of the main aims of their job. One person said, "The care enables me to keep certain levels of independence and dignity. And enables me to keep working." One member of care staff said, "My job is to enable people to live as independently as they want to."

Relatives told us that the care their family member received had also enabled them to remain the main carer. One relative said, "The care benefits really us. To know that two people [staff] are coming in to bathe and dress [names of family members]. It's great for the family." Another relative also told us that without the care, they would no longer be able to be the main carer for their family member. One relative said, "The care is to enable me to get on and do other things and to enable me to go out. I couldn't do without them."

People told us that they were aware of their care plans and were involved in developing these, based on their needs and choices. People were satisfied with how they were enabled to make choices in how they wanted to be looked after. Choices included their gender preference of care staff; choices of what to eat and drink and choices in managing their own prescribed medicines.

Advocates are people who are independent and support people to make and communicate their views and wishes. Advocacy services were in use and these enabled people to be supported in managing their affairs by an independent agent.

Good

Is the service responsive?

Our findings

People told us that they were satisfied with how staff looked after them. One person said, "I am very satisfied with the care and service I get." Another person said that their care was of a "very high standard." One relative said the care was "very good." A community professional told us that the staff were responsive to the needs of the people that they looked after. There was a designated team of staff available to respond quickly to support people; this was following their discharge from hospital or when their main carer was not available.

People and their relatives told us that they were involved in the reviews of their individual care plans. One person said, "Not so long ago my care plan was reviewed with me. The new care plan is not very old. I know what's on it because I told [name of reviewing member of management staff]." Another person said, "I have a review once a year." One relative said, "Yes, I have been involved in [the review of] the care plan." Care staff told us that they found the care plans were easy to follow and read these before providing people with their care. Care plans and risk assessments were reviewed and kept up-to-date to ensure that staff had the guidance to meet people's assessed needs.

People's individual needs were responded to and their care plans and provision of care were kept under review. One person said that their care plan had been changed due to an increased level of their needs associated with their health condition. Another person said, "I had to have an increase in care due to not being able to walk about so well and I needed more personal care."

Information about people's life histories was recorded in their individual care plans. However, these were brief in detail; the registered manager advised us that this was an identified area for improvement. Notwithstanding this, people said that staff knew them as a person. One person said, "Because of the regularity of staff, they have got to know me very well." One relative said that the care staff had come to know their family members' "little ways"; this included understanding their complex communication needs. One member of care staff told us that because they regularly looked after the same people, this had helped them in getting to know people as individuals, and vice versa. They said, "The continuity of care means you get to know what people like, not like or when things are wrong. One person [living] with dementia has got to know my face." The community care manager told us that people's dementia care needs were responded to by staff who understood and knew how to look after people living with this condition. This also included responding to a person's change of need and appropriately carrying out a new risk assessment.

When needed, people were helped to go out into the community or take part in activities that were meaningful to them. One member of staff described the support they gave which enabled a person to go shopping, bowling, take exercise and go to the cinema. One person said that their care calls had helped reduce their risk of social isolation.

Most, but not all, of the people surveyed told us that they knew what to do if they wanted to make a complaint. However, all of the responding surveyed relatives said that they were aware of how to use the provider's complaints procedure, if they needed to.

People who we spoke with told us the names of the people who they would contact if they wanted to raise a concern. People's relatives said that they were satisfied with how the provider responded to their complaint and said that they were satisfied with the outcome. One relative said, "There were some little things that went wrong." However, they told us that they were satisfied with the remedial action the provider had taken in response to their concerns. Another relative told us that they felt "listened to" when they had followed the provider's complaints procedure. They also said that the provider's action was "pretty prompt" and that they were satisfied with the outcome.

Good

Is the service well-led?

Our findings

There was a registered manager in post and they were supported by office based staff, a team of management and care staff and by the provider's different organisational departments. Staff had positive comments about the registered manager's leadership style. This was described to be "approachable." One member of staff said, "I get on really well with [registered manager]. Because if I have a problem, I ring her up. She has a good understanding and a really nice person to go to."

Most people and all of the relatives told us that they knew who to contact in the office, should they have a need to do so. However, one person told us that the communication between office staff and the registered manager was not always satisfactory. The registered manager advised us that they had identified this as an area for improvement, with actions already in place. The local contracts manager told us that the service provided people with good, quality support and care. Community professionals also had positive comments to make about the agency.

Staff members were enabled to make suggestions in improving the standard of people's care. This was during their one-to-one supervision sessions and during two-monthly staff meetings. Minutes of staff meetings also showed that staff were reminded of their roles and responsibilities; this included following the provider's safeguarding and MCA policies and procedures. Care staff told us that they found their meetings to be 'informative'. One member of care staff said, "The staff meetings are good. They keep you up-to-date with information. We can also discuss what needs to be sorted out or people we may have concerns about."

The provider had carried out surveys during 2015; these had enabled people and relatives to share their views about the standard of care they received. The collated results of the survey showed that people were satisfied with how they were being looked after. The registered manager told us that, due to people's level of satisfaction, no remedial actions were needed. They said, "There is nothing significant to improve the standard [of the service] based on the results [of the survey]."

Other quality assurance systems included the improvement of training of staff. Staff training records showed that there were some areas for improvement. The registered manager told us that there had been improved induction training for staff. Plans were also in place for staff to complete training in dementia awareness and the application of the MCA. Timescales for completion of this training were set. They said, "I would like to think that we will have everyone trained in dementia [awareness] or updated by end of May 2016." Staff training in MCA was arranged to take place on 16 March 2016.

Audits were carried out on completed MARs and care records. One care manager described the process of the audits and was satisfied with the accuracy and completion of these records. In the event of any deficiencies found, systems were in place to retrain staff and remind them of their accountability and responsibility in maintaining accurate records. Records we looked at were maintained to a satisfactory standard.

Accidents and incidents were recorded and members of staff were aware of their different responsibilities in

recording and managing these. The registered manager told us that there was a system in place for the information to be shared with the provider. The provider would advise the registered manager of any further action that may need to be taken to minimise the risks to people. The registered manager told us that there were no emerging patterns or themes for quality measures to be put in place.

Managers carried out unannounced 'spot checks' to observe staff at work. The 'spot checks' were to ensure that staff were respectful of people's privacy and dignity and that they were following safe practices. These included, for example, wearing disposable gloves and aprons, to minimise the risk of cross-infection when looking after people with their personal care.

Staff said that they had no reservations in blowing the whistle if they witnessed or suspected that people were being placed at the risk of harm. One member of care staff said, "Whistle blowing is if there is something going on and you need to inform someone in confidence. And you would not be victimised for bringing it [concern] up. Someone would be office staff or you would go the local authority or CQC."

Records we held about the service confirmed that notifications had been sent to CQC as required by the regulations.