Care Quality Commission

Day And Nightcare Live In Limited

Day and Nightcare Live-in Care Ltd

Inspection report

46 Market Square
Witney
Oxfordshire
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31 January 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We conducted an announced inspection of Day and Nightcare Live in Care Ltd on 31 January 2017.

Day and Nightcare Live in Care is a subsidiary of Day and Nightime DCA Witney. They provide live in carers to both the private sector and those who are funded by the local authority. At the time of our inspection 12 people were using the service.

There was not 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. At the time of this inspection the manager was applying to CQC to register as registered manager.

The service was operating from a location that was not part of the conditions of their registration. This address was 9 Hollow Way, Cowley, Oxford, OX44 2NA.

Before the inspection we asked the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. This document had not been completed.

People told us they were confident they would be listened to and action would be taken if they raised a concern. The service sought people's opinions through regular surveys. The service had systems to assess the quality of the service provided. Learning needs were identified and action taken to make improvements which promoted people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care. However, there was no system to investigate and analyse accidents and incidents. The manager was aware of this concern and was planning to put a system in place.
We were greeted warmly by staff at the service who seemed genuinely pleased to see us. The atmosphere in the office was open and friendly.

People told us they were safe. Staff understood their responsibilities in relation to safeguarding. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

People were supported by staff who were knowledgeable about people's needs and provided support with compassion and kindness. People received quality care that was personalised and met their needs.

Where risks to people had been identified, risk assessments were in place and action had been taken to manage these risks. Staff were aware of people's needs and followed guidance to keep them safe. People

received their medicines as prescribed.

There were sufficient staff to meet people's needs. Staffing levels were consistently maintained. The provider followed safe recruitment procedures and conducted background checks to ensure staff were suitable for their role.

Staff understood the Mental Capacity Act 2005 (MCA) and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected.

Staff spoke positively about the support they received from the manager and senior staff. Staff supervision and meetings were scheduled as were annual appraisals. Staff told us the manager was approachable and there was a good level of communication within the service.

People told us the service was friendly, responsive and well managed. People knew the manager and staff and spoke positively about them. The service sought people's views and opinions and acted upon them.

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.

There were sufficient staff deployed to meet people's needs.

People told us they felt safe. Staff knew how to identify and raise concerns.

Risks to people were managed and assessments were in place to reduce the risk and keep people safe. People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and understood and applied its principles.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respectful and treated people and their relatives with dignity and respect.

Staff gave people the time to express their wishes and respected the decisions they made. People were involved in their care.

The service promoted people's independence.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and gave clear guidance for staff

on how to support people.

People knew how to raise concerns and were confident action would be taken.

People's needs were assessed prior to receiving any care to make sure their needs could be met.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service was operating from a location that was not part of the conditions of their registration. There was not a registered manager in post.

There was no system to investigate and analyse accidents and incidents.

The manager monitored the quality of the service and looked for continuous improvement.

Care Quality Commission

Day and Nightcare Live-in Care Ltd

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 the 31 January 2017. It was an announced inspection. We told the provider two days before our visit that we would be coming. We did this because the manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that someone would be in. This inspection was conducted by one inspector.

We spoke with three people, one relative, five care staff, the office manager and the manager. We looked at four people's care records, four staff files and medicine administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the service and getting their views on their care.

Before the inspection we looked at notifications we had received. A notification is information about important events which the provider is required to tell us about in law. In addition we contacted the local authority commissioner of services to obtain their views on the service.

Good

Is the service safe?

Our findings

People told us they felt safe. Comments included; "Oh yes, I do feel safe with them", "My carers make me feel safe" and "I feel safe with the agency staff".

People were supported by staff who could explain how they would recognise and report abuse. Staff told us they would report concerns immediately to their manager or the senior person on duty. Staff were also aware they could report externally if needed. Comments included; "If I saw finger marks on somebody's body, I would report this immediately to the office and document this in care logs", "We are taking care of vulnerable people and we have to report things. I would report my concerns to the office and if they would not act on it, I would report them further to the local safeguarding team" and "I'd report to my line manager and call social services". The service had systems in place to report concerns to the appropriate authorities.

Risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been taken to manage the risks. For example, one person could become breathless due to their condition. The person could mobilise independently using a walking frame but could only walk for short distances. Staff were guided to monitor the person closely and 'give [person] time when walking'. If the person became breathless staff were guided to encourage the person to use their wheel chair. Staff we spoke with were aware of this guidance.

Another person was at risk of falling. The person could mobilise independently but was at risk of tripping in their home. Staff were guided to 'ensure there are no tripping or slipping hazards before commencing care' and 'ensure the bathroom floor is dry and soap free'. Other risks assessed and managed included skin care and environmental risks.

Staff told us there were sufficient staff to support people. One staff member said, "We could always do with more but we manage just fine. I think we meet people's needs from a staffing point of view".

Staff were effectively deployed to meet people's needs. The manager told us staffing levels were set by the "Dependency needs of our clients". People had live in staff who provided 24 hour support to people in their own homes. Staff rotas evidenced planned staffing levels were consistently maintained. We also saw many of the people had family members and other healthcare professionals who supported them in addition to the support provided by the service.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff were of good character and were suitable for their role. This allowed the manager to make safer recruitment decisions.

Where people needed support with medicines, we saw that medicine records were accurately maintained and up to date. Records confirmed staff who assisted people with their medicine had been appropriately trained and their competency had been regularly checked. Care plans highlighted any potential side effects

relating to people's medicine. For example, one medicine could 'make the person sleepy'. Staff we spoke with told us they had received medicine training and were confident supporting people with their medicines. One member of staff said, "I've had the training and my competency is regularly checked. In fact I think I'm probably due for another check soon".

Good

Is the service effective?

Our findings

People told us staff knew their needs and supported them appropriately. Comments included; "Oh yes, they are effective. They know what I need", "They are able to meet my needs" and "I have to say that in my opinion they are really well-trained". One relative commented, "Their carers are well trained. This is our first living-in carer and he seems to be quite good at noticing things. My father is really relaxed with him and does not complain, which he did with the previous care provider".

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they received an induction and completed training when they started working at the service. This training included safeguarding, moving and handling, dementia and infection control. Induction training was linked to 'skills for care common induction standards' which is a nationally recognised program for the care sector. Staff spoke with us about their training. Staff comments included; "The induction was really good. First, you need to be introduced to your client before you start shadowing. Sometimes our clients get confused if they see too many carers, so this was done in a really calm and friendly manner" and "The initial induction consisted of five day long training". We saw some staff training was out of date. However, the manager was aware and had booked training events for staff to ensure they would be up to date. This had not impacted on people's care or staff's ability to effectively support people.

Staff told us, and records confirmed they had effective support. Staff received regular supervision. Supervision is a one to one meeting with their line manager. Supervisions and appraisals were scheduled throughout the year. Staff were able to raise issues and make suggestions at supervision meetings. For example, one staff member requested some training and we saw this had been booked.

Staff told us they were supported through supervision. Staff received supervision every three months unless the person they supported was ill. Staff then received monthly supervision to ensure the person and staff received appropriate support. One staff member said, "We receive our supervision every quarter. However, if the client is unwell, we have the supervision every month in order to know how to meet our client's need". Another said, "I have my supervision every quarter".

Staff were also supported through spot checks to check their work practice. Senior staff observed staff whilst they were supporting people. Observations were recorded and fedback to staff to allow them to learn and improve their practice. Observations were also discussed at staff supervisions.

We discussed the Mental Capacity Act (MCA) 2005 with the manager. 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. The manager was knowledgeable about how to ensure the rights of people who lacked capacity were protected. We saw one person had appointed a relative to have lasting power of attorney allowing them to make decisions relating to the person's' property and affairs'. The person made their own decisions relating to care and welfare. This

had been authorised by the Court of Protection.

Staff demonstrated an understanding of the MCA and how they applied its principles in their work. Staff comments included; "Things relating to mental capacity are always recorded in a client's care plan. We always presume the person has got capacity to make a decision, unless the person was assessed as lacking the capacity" and "The MCA tells us that we have to presume that everyone has got capacity. When the client is assessed as not the having capacity, every decision has to be taken in their best interest".

The service sought people's consent. Care plans and reviews of care and support needs were signed and dated by the person evidencing they had provided consent. We asked a member of staff how they ensured they had the person's consent before providing support. They said, "It's simple, I talk to them and ask".

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included people's GPs and district nurses. Details of referrals to healthcare professionals and any advice or guidance they provided was recorded in people's care plans.

Most people did not need support with eating and drinking. However, some people needed support with preparing meals and these needs were met. People had stipulated what nutritional support they needed. For example, one person had stated 'I have a very good appetite and like all sorts of food'. Another person had compiled a weekly menu of meal choices and this was held in the person's care plan. The person went on to state they 'need encouragement with eating and drinking' and wanted the 'carer to sit with me and have our meals together'. Daily notes evidenced this person's wishes were respected. One staff member spoke with us about people's nutritional needs. They said, "I only help with meal preparation as clients are independent. I have no one with weight loss or food issues. If we do we monitor them closely". One person said, "They give me choices of food, which is really good as in this matter I'm dependent on the carers".

Good

Is the service caring?

Our findings

People told us they benefitted from caring relationships with the staff. Comments included; "I know the girl that takes care of me. She is an excellent carer", "The one I've got (staff) is absolutely brilliant" and "They are helpful, patient and caring". A relative said, "The carer visiting my father is excellent. We had difficulties to find a service that is able to provide that level of care".

Staff spoke with us about positive relationships at the service. Comments included; "No two days are the same which is great as I am a people person" and "I am caring, friendly and personable. I have formed some strong bonds with my clients".

People's dignity and privacy were respected. When staff spoke about people to us they were respectful and they displayed genuine affection. Language used in care plans was respectful. One relative told us, "As far as I can tell, my father is treated with respect and dignity". Care plans reminded staff about people's dignity. For example, one person had stated in their care plan they were 'very private'. Staff were reminded to 'respect this person's privacy' and to 'treat them with dignity and respect at all times'. Dignity posters were displayed in the staff training area. These reminded staff that 'care is about the whole person' and that 'people make the difference'.

We asked one staff member how they promoted people's dignity and respect. They said, "I always greet people and say hello. I cover them up with personal care and I communicate with them, not only to inform them but also to distract them from any embarrassment they may feel". Another staff member said, "I treat people with respect and dignity. This means I refer to them by their preferred names, I talk to them and explain things to them".

People's independence was promoted. Care plans guided staff on how to promote people's independence. For example, one person liked to 'wash themselves'. Staff were guided to 'let the person be as independent as they can be' and to 'wash the areas the person cannot reach'. One staff member said, "I encourage them (person) to do as much as they can. I won't do it for them if they can do it. You mustn't take those little things away as they will lose the skill". Another said, "We encourage people to do as much as they can. We cook together, we talk together and we go shopping together. This is really important to help people to be independent for as long as they can be independent".

People were involved in their care. We saw people were involved in reviews of their care and able to raise issues and comment on their care. For example, at one care review the person had commented 'the carers I have are all very friendly and easy to talk to. I am very happy'.

Staff told us how they involved people in their care. Comments included; "They are involved in making decisions. We explain things to them and they decide what to do next. What to eat, what to wear and what to do with their time" and "I ask them their preferences. How they would like to be washed, what products to use, that type of thing".

The service ensured people's care plans and other personal information was kept confidential. People's information was stored securely at the office and we were told copies of care plans were held in people's homes in a location of their choice. Where office staff moved away from their desks we saw computer screens were turned off to maintain information security. A 'data protection' policy was in place, available to both people and staff. This provided people with information on how their personal and confidential information was managed and protected.

People's care was recorded in daily notes maintained by staff. Daily notes recorded what support was provided and events noted during the person's day. These provided a descriptive picture of the visit. For example, one staff member had noted in one person's care plan 'good day today. Supported [person] to attend church, helped to bed and had a chat'. Daily notes also informed staff of any changes noted to the person's condition or wellbeing.

'Weekly client reports' were also maintained and supported the daily notes. One we saw stated '[Person] had a good week but still needs encouragement to take fluids'. These reports not only provided a brief overview of the person's week but also reminded staff and people's families of people's ongoing support needs.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to accessing the service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person's care plan stated the person 'liked to attend the local day care centre and also liked to go to church'. Daily notes evidenced this person was supported to follow their interests.

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person had a condition that affected their memory. Throughout the care plan staff were guided on how to support this person. The care plan stated the person 'needs time, physically and cognitively to be able to engage' and 'I can express my wishes'. Personalised guidance included the person's wishes. For example the person had stated 'can carers please check I have put my make up on in the right places'. Daily notes evidenced this guidance was followed.

People received personalised care that responded to their changing needs. For example, one person's condition was regularly changing and records confirmed staff were working closely with the person's GP. Regular reviews of this person's medication had been conducted and the GP had changed the person's medicine to respond to their needs. Another person's condition had changed and they required a piece of medical equipment as part of their support. Staff had then received training on the use of this equipment from a local NHS Foundation Trust to enable them to support the person safely.

People were supported by staff who understood, and were committed to delivering, personalised care. Staff explained to us how they tailored people's care to suit their personal preferences. Staff comments included; "This is care for that person. It's been discussed with them so we provide care their way" and "Care plans provide us with knowledge on how to address the needs of every client in an individualised way. People are different and you have to respect that".

People knew how to raise concerns and were confident action would be taken. People's comments included; "I have raised one complaint and they acted on it", "I have never had a reason to complain" and "I have never raised a complaint". Staff told us they would assist people to complain. One staff member said, I'd help someone complain. I'd talk to my line manager about the problem but I would get the clients permission first".

The provider's complaints policy was available to people and their relatives. The service had systems in place to record, investigate and analyse complaints. There had been no complaints recorded for 2016. Historical complaints had been dealt with compassionately in line with the provider's policy.

We saw numerous compliments and thank you cards from people and their families. These praised and thanked staff and the service for that had been provided.

People's opinions were sought and acted upon. People were called by the service and their conversations noted to enable the manager to act if people raised issues or concerns. For example, we saw that where people had hospital or private appointments the manager would try to adjust staff handover times to the person's convenience. We saw one logged call where a relative had reported that the person, in their first week of care was 'disappointed with the carer'. The manager changed the staff member and the relative later reported there had been 'a 200% improvement'.

The provider sought people's opinions through surveys which asked questions relating to all aspects of care and support. We saw the results of the last survey which were very positive with no issues or concerns raised. The manager told us they were planning for a survey to be conducted in 2017.

Requires Improvement

Is the service well-led?

Our findings

There was not a registered manager in post. The registered manager left the service in October 2016. The new manager had managed the service since November 2016. At the time of this inspection the manager was applying to CQC to register as registered manager. The service was also operating from a location that was not part of the conditions of their registration. This address was 9 Hollow Way, Cowley, Oxford, OX4 2NA. An application to register this new location had been submitted but could not be processed as there was not a registered manager in post.

Before the inspection we asked the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. This document had not been completed.

The provider had documents in place to record, and investigate accidents and incidents. There were no accidents or incidents recorded for 2016. However, there was no system in place to monitor and analyse accidents or incidents to look for patterns or trends. We spoke with the manager about this who said, "I am aware of this and it's on my list of things to do. The last (registered) manager left in October 2016 and I am working through several uncompleted and missed issues from that time. We had no accidents I am aware of in 2016 but I will be putting a system in place soon".

People and their relatives told us they felt the service was well led. One person said, "I know how to call the office. I think the place is run smoothly". Staff spoke positively about the manager. Staff comments included; "They (management) are very supportive. We always work together to find a solution to a problem. The communication between us and the management is really good", "I have worked with [manager] for many years and we get on really well. She is approachable and really helps where she can" and "The previous manager left in October but we are getting on really well with the acting manager".

Staff told us that learning from was shared through staff meetings and briefings. The provider had recently reintroduced staff meetings, the first being held on 20 December 2016. Staff were able to raise and discuss issues and were briefed by the manager. Staff told us about staff meetings. Comments included; "We now have regular staff meetings. If there are any concerns, we discuss them during the meetings and we try to find a way to improve", "I find them (meetings) ok. They would listen to me and my concerns. Actually, they have done it in the past. One client was referred to an occupational therapist and re-assessed after I spoke to the manager" and "We have started meetings again which is a good thing". Staff also told us learning was shared through, "Updates from the office, phone calls and texts. We also have the weekly handover sheets".

The manager told their vision for the service. They said, "I'm aware this service needs improving and I am up for that. My focus will be on our clients and supporting my staff. I want this to be a safe and responsive service that puts people first".

The manager monitored the quality of service provided. Regular audits were conducted to monitor and assess procedures and systems. Audits covered all aspects of care. Audit results were analysed and resulted

in identified actions to improve the service. For example, one audit identified several care plan reviews were overdue. The manager created a review plan which detailed the date of the last review and the new review date. The process of reviewing these care plans was underway. Another audit had identified some staff training was out of date. Again, a plan of training was created with new completion dates for staff. Records confirmed training events to achieve this had been booked.

There was a whistle blowing policy in place that was available to staff across the service. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.