Northern Community Care Line Limited

Northern Community Careline Services

Inspection report

Community Care Line Services
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Good**
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

The inspection of Northern Community Care Line took place on 27 September and 4 October 2016, and was announced. The service had previously been inspected in October 2013 and found to be compliant with all regulations at the time.

Northern Community Care Line provides personal care support to people living in the North Kirklees area of West Yorkshire. At the time of the inspection they were supporting 77 people.

There was a registered manager in post and we spent time with them. 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.

People and relatives said they felt safe when with staff from Northern Community Careline as they knew what they were doing and saw regular staff. Rotas were planned around continuity of care provision which meant people were able to build relationships with staff.

Medicines were administered safely and staff knew how to respond to any concerns.

Staff had regular contact with the office and informal discussions took place around workloads and practice issues but there was little formal supervision. All staff had received training in the main skill areas and some of these were due for a refresher. This is a breach of Regulation 18 Health and Social Act 2008 (Regulated Activities) Regulations 2014 as staff did not receive regular supervision and some training had expired.

People had support with nutrition and hydration where this was part of their care plan and staff knew when to request additional external support from other health and social care providers.

The registered manager understood the principles of the Mental Capacity Act 2005 and staff were aware of the importance of seeking a person's consent before undertaking any tasks.

People spoke positively of the staff saying they were caring and kind. Reviews took place but these needed to be more detailed and to show who had been involved.

The service had a reputation for supportive end of life care and was spoken highly of by other agencies in this regard.

Care records were person-centred and showed how people's needs were to be safely met and in their preferred way. The service was flexible and accommodated additional requests as much as possible as long as they had the capacity to do so.

The registered manager was spoken highly of and staff felt supported. People told us they had seen the registered manager delivering care themselves and felt able to approach them. The quality assurance systems were in existence but needed further development to ensure that changes and improvements to the service were evident.

You can see what action we told the provider to take at the back of the full version of the report.

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 told us they felt safe and were supported by a consistent staff team.

Risks were identified and plans put in place to reduce the likelihood of harm.

Medicines were administered in line with current guidelines.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive regular supervision and some refresher training needed updating.

The service was aware of the requirements of the Mental Capacity Act 2005.

Staff understood how to support people safely with various dietary needs and requested health and social care input as required.

Is the service caring?

Good

The service was caring.

Staff were spoken of highly and demonstrated a detailed understanding of people's needs.

The service had developed a reputation for sensitive end of life care.

Is the service responsive?

Good

The service was responsive.

The service was flexible and responded to people's needs as much as possible.

Care records contained all the necessary information and were reviewed at least annually.

Complaints were logged and dealt with in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

Feedback from people and relatives was positive, and staff felt supported by the registered manager.

However, quality assurance processes were weak and it was not always evident what checks were in place to ensure effective delivery of care.

Northern Community Careline Services

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 27 September and 4 October and was announced. The provider was given 13 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office.

The inspection team took place with one adult social care inspector.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was also used to assist with the planning of our inspection and to inform our judgements about the service. We also checked information held by the local authority safeguarding and commissioning teams.

We spoke with four people using the service and five of their relatives. We spoke with five staff including two carers, one senior carer, the care co-ordinator and the registered manager.

We looked at five care records including risk assessments, three staff records, minutes of staff meetings, complaints, safeguarding records, medicine administration records and quality assurance documentation.

Good

Is the service safe?

Our findings

We discussed with people about the continuity and timing of their service. One person told us, "It's nearly always someone I know. The only changes are when people are on holiday. They always arrive on time." One relative said, "It's the same staff and my relation is familiar with all of them. They are comfortable with all the staff." Another relative told us, "It's usually the same staff who visit. There is a rota of four people." A further relative said, "We used to have the same staff but there have been changes recently due to annual leave." This showed the service had established, wherever possible, regular provision of staff for people to minimise disruption and enable the building of relationships.

One relative also told us, "Times of calls do vary occasionally but they are generally consistent. I have discussed it with them and they are trying to improve." Another relative advised us, "They do turn up on time and ring me if they are going to be late so I don't worry." Staff said they felt they had enough time between visits to travel and that call times were long enough to complete everything that was needed.

The care co-ordinator showed us the office systems and how staffing rotas were determined. These accommodated staff's annual leave and regular working patterns including the people they regularly visited wherever possible. The care co-ordinator said as so many of the staff had the same people to visit it was possible to allow for hospital visits or other such appointments as this person-specific knowledge was used to re-schedule visits wherever possible. If emergencies arose during the day then the care co-ordinator or registered manager would support as needed.

Due to the close level of scrutiny on a day to day basis the care co-ordinator reported only one missed call for the past eighteen months which was due to an error in understanding. Staff came into the office on a weekly basis to collect their rotas for the forthcoming week and it was often at this point any anomalies were identified and amended. This promoted effective communication between care staff and the office staff.

The registered manager advised us the service was looking to recruit more care staff as the demand was there. They said, "We have pulled together as a team and helped out. If we do not have the capacity we will not take new service users." They were also proud they did not use agency or bank staff as they felt it was important people had the same staff to build relationships.

The service had a comprehensive recruitment and selection procedure in place. We looked at staff recruitment files and found the service had carried out appropriate checks ensuring references were obtained and Disclosure and Barring Checks were completed as required. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We asked people if they felt safe receiving the service. One person told us, "I feel safe with all the staff who visit and I've only been having the service recently. They do a great job." We discussed with staff their understanding of safeguarding. One staff member said, "I know that safeguarding concerns may include financial, physical or emotional elements. Someone may have an unexplained black eye or no money even

though it is pension day. We could also find them crying and find no obvious reason." They explained they would try and comfort the person and try and find out the basics but would be careful not to ask too many questions. "I would ask the person if it was OK to report it given the concerns and speak to the manager" said the staff member. They also said they would document what they had found and said they had never actually experienced anything like this despite working with the service for over six years.

Another staff member said they would raise concerns if they were concerned about a person's finances, medicines not being available or a person not receiving adequate health checks. We looked at safeguarding records and found that issues were reported appropriately including where other providers were noted for poor practice. The service had reported one concern and acted as an advocate for a vulnerable person which showed understanding of their responsibilities in keeping people safe.

We discussed with staff what training they had received in relation to moving and handling. One staff member explained, "I have done both theory and practical. I watched other staff perform specific techniques such as moving someone in a hoist or doing a log roll on the bed." They continued, "If I found any difficulties with a hoist I would ensure the person remained in bed and was comfortable. I would not move them as this would be unsafe and report the broken hoist, or if there were any other concerns I would report them to get the person re-assessed." Staff told us they had received spot checks to review their competency and we saw evidence of these checks.

Moving and handling risk assessments were completed with a baseline assessment which outlined what the person's need was, their stature, history of falls and their abilities. Possible risk factors such as poor hearing or sight, agitation and pain levels were considered in terms of frequency and correlated to the tasks that needed completion to determine the best and safest method. Reference was made to pre-existing assessments carried out by occupational therapists and pertinent information pulled through to the service's own risk assessment tools. Each identified moving and handling need such as in and out of bed or moving from a sitting position to a standing one had a detailed specific handling plan. This referenced the number of people required, the method and equipment needed, and how much assistance the person was able to give. This showed the service had demonstrated how to ensure people were moved safely where assistance was needed and were reviewed on an annual basis or more if needed. Environmental risk assessments were also included which considered the location, fire risks, pets and core appliance information.

We spoke with people about the help they received with their medicines. One person said, "Staff help punch out the tablets from my pack if needed and place them so I can take them myself." One relative told us "My relation has an automatic carousel and if they are there when this opens they prompt them to take their medication." Another relative said they had never found any issues with medication.

Staff told us their role was limited to prompting out of a dosette box. One staff member advised us, "I find the box, check that no tablets are missing and that those in the sections match the times and days needed. I then check the record and pop out the tablets, usually into an egg cup, and prompt the person to take them with a glass of water." They also said if the person refused they would record this on the medicine administration record. The registered manager advised medicine competency checks were carried out but we could find no written evidence of this. They agreed to rectify this promptly.

Staff told us they had a plentiful supply of personal protective equipment such as gloves, aprons and hand sanitiser and knew when to use them appropriately.

Requires Improvement

Is the service effective?

Our findings

One relation said "I feel all the staff know what they are doing." Another relative advised us "Staff do contact me if they have any concerns such as if my relation is getting sore. They will always ring me and leave notes in the care file. They are on the ball with pressure care." A further relative told us "I am confident they know what to do. They always ask permission first and are very courteous."

One staff member told us they had had an induction which included "lots of booklets, shadowing double up visits and watching DVDs." They said this had helped them in their role. Another staff member said they had spent two weeks shadowing more senior colleagues and getting to meet people that they would eventually be supporting. We saw that newer members of staff completed a workbook over a period of up to three months which focused on key skills and abilities such as fire safety, risk assessment, infection control, moving and handling, safeguarding, communication and pressure care. The information was detailed with the staff member having to complete questions about their knowledge.

Staff told us they received supervision. One staff member said, "It's where I am able to raise any concerns or issues are discussed. It is written down and I am happy to raise stuff. I've also had an appraisal." A different staff member told us that supervision occurred roughly every six months and they had the opportunity to prepare for this in advance of the meeting. We saw few completed supervision records and these were brief. New members of staff had received supervision but the detail of the discussion was lacking. The registered manager advised supervision was supposed to be three-monthly but this had not always happened and appraisals were in the process of being completed. They stressed they had an 'open door' and many discussions took place informally. This meant there was a risk that issues were missed as much of the focus was on verbal communication and there was no evidence to show that staff were receiving appropriate support to perform their role well.

We also asked staff about what training they had undertaken. We were told most of the training was through a vocationally-recognised qualification (VRQ). VRQs are study-based, structured-training programmes which provide practical skill and knowledge required for a certain job. The candidate undertakes written tests as well as being assessed on the basis of workplace-related activities. One staff member had recently completed a programme about diabetes and we also saw safeguarding and dignity as other completed topics. One staff member told us if new training needs were identified then the registered manager would arrange training for staff. We asked staff how they would support a person with more complex behaviour. One staff member replied, "I used to visit someone with dementia and they could get upset. I would walk away and leave them to calm down, and then try again in a little while, having done other tasks in the meantime." This showed that staff understood how to support people effectively with more complex behavioural needs.

We looked at training records and found all staff had received training in moving and handling, dementia, diabetes, health and safety but some staff had not completed medication, first aid or infection control refresher courses recently. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff were not receiving up to date training or supervision to ensure they were

practising in line with current requirements.

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. We checked whether the service was working within the principles of the MCA.

Staff had a good understanding of mental capacity and how it can vary. One staff member told us, "A person has mental capacity if they can make a decision about whether to take their medicines, be at home or receive care. Sometimes this capacity can vary as a person may have a urine infection or have dementia. If this was the case then I would encourage them to take their medicine but I can't force them. I would ring the office and explain what has happened." The registered manager advised us no one lacked mental capacity that was currently receiving a service but they understood the process they needed to follow to ensure compliance with the MCA if this changed for anyone.

We were told by staff about people's different dietary needs such as needing a soft or mashable consistency of food if a person had swallowing difficulties. One staff member was able to relate this information to guidance received from the Speech and Language Therapy service and explain how this information was incorporated into a person's care plan. Another staff member said that any person who had diabetes controlled through insulin injections was supported through the district nurses with whom they had excellent relationships and would raise any concerns promptly.

One relative spoke with us about an incident that had occurred not long after beginning with the agency where they felt staff should have been quicker to seek medical advice but did stress this had not arisen again, and staff were fully briefed as to when to request this support. Another relation told us about a more recent visit where staff had called an ambulance as they were concerned for the person and this had proven the right thing to do as they were now receiving treatment. While in the office we overheard a conversation about a person's deteriorating health and how staff felt that a hospice bed should be obtained. This was followed up by swift conversations to the local authority social work team to ensure these concerns were flagged in a timely manner. This showed that the service responded in a timely and appropriate manner when concerns about people were raised.

Staff we spoke with had a detailed knowledge of effective pressure care. One told us, "We record the positional changes of people, whether they are on their left or right side or on their back. We keep a close eye on people in bed and report any concerns to the district nursing service. I am aware that heels and elbows are areas to watch for." Another staff member also told us about key pressure areas and the importance of regular checks. This meant the service was able to support people effectively and minimise the risk of poor skin integrity.

Good

Is the service caring?

Our findings

"I find the girls very friendly and no one has ever upset me" one person told us. Another said "The carers are very good. I have my regulars and they know my routine." One relative told us "The staff are very good and conscientious. They always respect my relation's wishes and choices." Another relative said "Staff are really good and engage with my relation well." A further relative said "The carers are amazing." One relative told us they often overheard positive interactions between care staff and their relation as they worked from home and staff did not always know they were there. This meant they had confidence in the consistency of attitude of staff visiting. We spoke with one health professional who spoke very highly of the service. They told us "the agency has never let us down. When I ring the office staff are always polite and very welcoming."

Staff were able to explain how they learnt about people's differing cultural needs. One staff member told us about one person's washing rituals that needed to be followed and how they ensured they were completing this correctly in line with the person's cultural requirements. Another told us about the use of communication boards to support a person who had specific communication needs so they could ensure they were meeting their needs appropriately.

The registered manager told us about a partnership with another local home care provider to deliver end of life care support. This had been developed from an increasing demand in the community for people choosing to remain in their own home and the service felt this was a particular strength of theirs. We saw evidence of specific end of life care plans for people and some highly complimentary feedback from family members. One note we read said "Day after day you ladies arrived in our home with a cheery greeting and gave yourselves to make [name] as comfortable as possible. You constantly treated them with dignity, respect and affection, and always with tenderness and understanding."

Staff understood how to care for a person reaching the end of their life. One staff member shared, "If I had any concerns about a person's pain levels I would talk to the district nurse, the community matron or the GP. I would support the person with their emotional wellbeing as much as their physical as people can get very anxious. This would extend to the family as well." Another staff member told us "We are aware the person is always in charge and we are guided by what they want. We work in partnership with other agencies where needed."

Staff were aware of the importance of respecting people's privacy and dignity and explained various ways in which they would do this. One staff member told us "I always make sure doors are shut, curtains closed and people are offered the choice of a shower or full body wash." A further staff member stressed the importance of explaining what it was they were doing all the time so that people felt reassured and comfortable.

Good

Is the service responsive?

Our findings

One person told us "I am respected and offered support as I wish to receive it. The carers follow my care plan and also do extra if I ask them. One of my regular carers always goes the extra mile." One staff member referred to people's involvement in the receipt of their care and how quickly the service responded if extra support was needed for short periods of time such as if the main family carer was away. They said the service could usually accommodate such requests.

One relative said "If I've had any query I just need to mention it and it's sorted. Communication is good." Another relative told us "The service is very responsive. If I need an extra call they will supply with only a couple of days' notice. They are very accommodating." The registered manager advised us there was an out of hours number which was covered between senior carers and themselves which allowed for staff to report any concerns and also to ensure staff had completed their later calls safely.

People had an initial assessment which considered their support needs along with being given a comprehensive service user guide outlining all relevant information. Support needs were logged on an individual care plan along with other key details such as preferred time and length of call, where activities took place in the house, environmental and other risk assessments. We were told by one staff member that two weeks after care had started people receiving the service were spoken with to determine their views. We did not find any written evidence of this.

Care records contained key contact information such as GP and next of kin along with an outline of the care package. In one care record we looked at we saw a person's health had improved so much call visits had been reduced from four visits a day with two carers to just one daily visit. The initial care plan for this person had been very detailed outlining what support was to be offered on each visit including the use of equipment as necessary. This detail included phrases such as 'when they are ready', 'to support to dress' and 'to support using the turner either to the chair or back to bed, depending on how they are feeling.' This demonstrated the service was person-centred in its practice and guidance by ensuring staff were reminded of the importance of meeting people's needs as they wished them to be met.

Other care records included details of which footwear people were to be encouraged to wear and their preferences for breakfast. This again indicated the depth of information the service had sought to ensure that people had their needs met as they wished them to be.

Records were kept in people's homes outlining all the key tasks that had been undertaken and these informed staff or family of any concerns about the person. One staff member told us, "If a person's needs changed significantly then the care record would be amended to reflect this."

We asked people if they had a review of their care needs. One person told us they had never had one. However, as the staff were regular they knew what was wanted and this was not an issue. One relative said "I have taken part in reviews of my relation's care with social workers and the agency." However, another told us they had not and a further relative said it had been some time ago. This meant the service was not always

aware if their service was still meeting people's needs as they wished them to be met.

However, we did see that the care staff contributed to local authority reviews of people's care needs. In one record we saw a senior carer speak about their concerns for a person who had been very agitated and how they had reassured them. They had been aware the person had a urine infection at the time and so presented as more unsettled. This showed the service understood what was happening to each person receiving a service but this was not always formally recorded. People's care records were updated annually but it was not always clear how decisions had been reached.

We spoke with people receiving the service and their relatives about complaints. One person said "I had concerns about one staff member some time ago but they were removed. I felt the action taken was right." A relative told us "Carers do not always follow the care plan or respect my relative's wishes. They don't always do every necessary task such as ensuring fingernails are clean." They advised us they had raised concerns about this and felt the situation was improving slowly. We did see evidence that a meeting had been held with the person and their family to discuss these concerns. Complaints were logged with details of the issues and prompt remedial action taken. It was also shown that where learning had occurred as a result this was shared with staff at team meetings. This meant that the service was keen to ensure improvements were made where needed and that any poor practice was dealt with.

We looked at the compliments folder and found the service had received many commendations. One note said "[Name's] care has been much appreciated and you have always shown yourself ready to talk and meet our needs. All your staff have done their best for [name] and our family but a special thanks is made to [staff name] and [staff name] who have gone to outstanding levels of person-centred care and kindness." Another commented on the 'professionalism of staff' and a further focused on the impact on the family as much as the person receiving the care 'made my life much easier having such helpful carers.' We saw that where specific staff were named this information was passed onto the staff concerned so they were aware of the acknowledgements

Requires Improvement

Is the service well-led?

Our findings

One person told us they had changed provider and found this one was 'much better'. Another said "The service and carers are absolutely brilliant and I am very pleased." One relative said "It's an excellent service. I've had no qualms about it at all." Another told us "It is a very good service and they do look after us well." A further relative said "The manager is fantastic. They always check how I am (as well as the person receiving the service)."

The health professional we spoke with told us "The manager is always very honest. If they do not have capacity to support someone they will tell us rather than try and fit the person in which is no benefit to anyone." This demonstrated the service was focused on being only able to offer support where it was practical to do so.

We asked staff what they felt the values of the service were. One staff member said, "We are caring and people are not alone. We are there to help but not intrude." Another told us "Continuity of care and respecting people in their own homes. If we can't meet their needs we will try our hardest to find someone who can." The registered manager said "To be a good care company and support people in their own home for as long as possible." They were proud of the relationships they had built up with people receiving the service as they felt this was one of the service's strengths. They also spoke of their positive development of the end of life support they offered and how this had been well received.

The registered manager stressed their key achievements as having a good and stable staff team, a variety of people with differing needs that they were able to support and the development of the service's strength in relation to end of life care. They were assured they were providing a quality service through feedback from the annual questionnaire, and their regular contact with people receiving the service whether this was on the telephone or through visits.

Staff told us they felt supported. One said "If I have a problem I always say and it will get sorted out. I'm happy to raise anything. Nothing is seen as too silly." Another staff member said "I get a lot of support. I can vent my frustrations when I need to and in a safe way." They said "There is always someone available on the phone." The registered manager told us they had visits from the registered provider although we saw little evidence of written input. The last meeting had been held in April 2016 where key issues were discussed such as training for staff on the Care Certificate, reviews of care plans and complaints analysis. A further meeting had been scheduled for August 2016 but there were no notes to evidence this. However, the registered manager did say they were always available on the telephone if needed.

We saw evidence of staff meetings but the frequency was sparse. In 2016 there had been meetings in January and April. Minutes contained details of specific service issues and updates but did not always evidence staff comments or views. The registered manager explained as they were often delivering care themselves they could see where improvements needed to happen and advised staff on a more ad hoc, informal basis. We spoke with them about this and they agreed to ensure a greater frequency and content with a clear agenda to ensure policy and procedure updates were more formalised.

One staff member told us, "I love working here. We are all part of a team and we support one another." Another staff member said, "I love the continuity, hours and security of the job." We asked how they knew they were doing a good job. They said, "All people receiving the service are sent a questionnaire and we get positive feedback from that. The manager also does spot checks to make sure tasks are being carried out properly." Another staff member said that even though the service had lost a key contract a few years ago, many people chose to remain with them and they felt this was an endorsement of the high regard the service was seen in. The registered manager was also proud of how the staff team bonded and supported one another, and felt one of the service's key values was that they treated everyone like they would a member of their own family.

Although feedback was positive and staff were happy working in the company we could find little evidence of more formal quality assurance processes. The registered manager told us that they checked all daily note recordings on a two-three weekly basis but there was no log of this. They also checked care plans before they were sent out but again there was no written evidence to support this comment.

We saw people's views of the service had been obtained in the annual questionnaire. This had been completed in January 2016 and contained many positive comments such as 'You provide all the care I need', 'Nothing could be better' and 'So happy to see familiar faces time and time again'. However, there were also other comments such as 'Some of the carers that come when [name] is off could do with a bit more training in certain areas.' There did not appear to be an analysis of the findings or an action plan resulting from any concerns.

We did see evidence of calls made to people where there were issues about call times and these were remedied. The registered manager accepted that recording of what action had been taken needed to be more transparent so it was clear people's comments had been acknowledged and responded to.

On site quality spot checks were completed but these were mostly tick lists. The arrival time of the staff member was logged against the expected time of call, and most were within five minutes of the expected time. Checks were made against the appearance of the staff member, whether they referred to the care plan during the visit, their attitude towards the person during their visit and their adherence to the moving and handling policy. The answers were limited in terms of yes or no and grades given for punctuality, appearance, equipment, performance and attitude. There was a comments section for overall opinion with brief comments in most. Most staff had been observed at least once since the beginning of 2016 delivering care support which showed the service had some competency assessments in place.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have access to regular formal supervision and some training needed updating.