London Care Limited

London Care (Holloway)

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection was short notice which meant the provider and staff did not know we were coming until shortly before we visited the service.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

London Care is a domiciliary care agency which provides services to over 300 people in North London. The service predominantly caters for the needs of older people but also younger people with disabilities or other support needs.

From the telephone discussions we had with people using the service and a relative we found that people were usually satisfied with the way the service worked with them. People were confident about contacting staff at the agency to discuss anything they wished to and carers were thought to know how to care for people.

In many of the care plans we looked at, few risks associated with the care to be delivered were identified.

Summary of findings

We were told that this was because few risks involved although if this was the case it was not actually stated. We recommend that risk assessments more clearly show the general common potential risks considered and identify what is, or is not, specifically relevant to each person.

The service had access to the organisational policy and procedure for protection of vulnerable adults from abuse. We asked staff about how they would recognise any potential signs of abuse. The care coordinators we spoke with said that they had training about protecting vulnerable adults from abuse and were able to describe the action they would take if a concern arose. We were concerned that almost all of the care workers we spoke with seemed to have limited awareness of this when we asked about what they would do.

We spoke with the manager who explained the system used by the provider for both mandatory and optional training courses. We found the mandatory training covered core skills and knowledge for staff and induction training was in line with the Skills for Care Common Induction standards.

The agency had detailed policies, procedures or information in relation to the Mental Capacity Act 2005 (MCA). The provider informed us that they were aware of three people using the service who were subject to enduring power of attorney. Care staff we spoke with demonstrated little or no understanding of this area.

The care plans we looked at drew attention to individual needs such as how people communicate, their cultural identify and first language. The new care plan format contained a short pen portrait of the person as part of the information available to care staff. This helped to provide information which assisted carers to form a good rapport with the people they cared for.

We looked at the complaints record and found that 36 complaints had been made in the last year. The manager informed us that the majority of these had been about communication with the agency and about confusion over when carers were expected. We saw that the complaints had been resolved.

Apart from the registered manager we spoke with six care workers, a local authority commissioning team manager and two co coordinators. Everyone told us they felt improvements had been made to the service since the new manager had come into post but that there were still difficulties about clear and effective communication between care workers and office based agency staff.

In discussion with the manager during our inspection we were told about, and shown, the monitoring systems for the day to day operation of the service. Staff had specific roles and responsibilities for different areas and were required to report to the manager about the way the service was operating and any challenges or risks to effective operation that arose.

The manager told us that they sought people's views at least annually and we saw individual examples of feedback that had been received. However, we were told that there was no other formalised system for carrying out recorded surveys apart from people using the service, either regularly or at least annually of staff employed, other professionals in contact with the service or stakeholders.

We recommended that the service seeks advice and guidance from a reputable sources about risk assessments, ensure that staff have an increased awareness of the policies, procedures and information in relation to the Mental Capacity Act 2005 (MCA) and that communication between care workers and office based staff be reviewed to improve effectiveness.

There were two breaches of regulations. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. Care staff we spoke with were unable to demonstrate sufficient day to day working knowledge about how to respond to concerns about abuse.

Any risks associated with people's needs were assessed, updated at regular intervals and at times when changes to care needs were identified.

The service had access to the organisational policy and procedure for protection of vulnerable adults from abuse.

Requires Improvement

Is the service effective?

The service was not always effective. Staff supervision and appraisal lacked consistency which meant that not all staff were supported as well as they should be.

The service did well to respond to people's care and support needs, care plans accurately reflected the service that people were provided with. There was insufficient information or awareness of care staff about the Mental Capacity Act 2005 (MCA).

Requires Improvement

Is the service caring?

The service was caring. The overwhelming view from people using the service and their relatives was of a service that cared for people.

We saw a clear communication policy that included people's preferred methods of communication, which were documented, and the need for staff to always communicate with people effectively.

Good

Is the service responsive?

The service was responsive.The people who were using this service each had a care plan.

The plans described people's specific needs and reflected each person's lifestyle and preferences for how care was provided. Care plans were updated at regular intervals to ensure that information remained accurate and reflected each person's current care and support needs.

Good

Is the service well-led?

The service not always well-led. The lack of a broader system for obtaining feedback from staff, health and social care professionals and other stakeholders meant that not as much was being done as required to seek views about the quality of the service.

Requires Improvement

Summary of findings

However, we recommend that the provider take steps to gather feedback from staff about their overall level of concern about communication between care workers and office based staff to ensure effective cmmunication.

London Care (Holloway)

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.

The provider was given 48 hours' notice because the location provides a domiciliary care service. We carried out two visits to the agency on 12 January and 9 February 2015. This inspection was carried out by three inspectors who were supported by an expert by experience who made telephone calls to people using the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for people using a domiciliary care agency.

We looked at notifications that we had received and communications with people's relatives and other professionals. These included information from local authority safeguarding teams, other notifications and examples of how the service had responded to complaints.

During our inspection we spoke with five people using the service, one relative, six care workers, a local authority commissioning team manager, two care co coordinators as well as the registered manager.

We gathered evidence of people's experiences of the service by conversations we had with them and by reviewing other communication that the service had with these people, their families and other care professionals.

As part of this inspection we reviewed ten people's care plans and care records. We looked at the induction, training and supervision records for the staff team. We reviewed other records such as complaints information and quality monitoring and audit information.

Requires Improvement

Is the service safe?

Our findings

All but one of the people we spoke with had positive comments about the service. People thought the service had improved greatly since the new manager was appointed in the spring of 2014.

People told us "they treat me with respect, they take care of my needs", "the carers are good, they treat me with respect and are very polite", "I feel ever so comfortable when they are around I know (my relative) is safe here because they are look after them all the time, I just let them get on with it."

Everyone we spoke said they would be more than confident to speak up about any form of abuse or harm. They said it was a lot easier to speak to management since the change in manager.

Care staff were unable to demonstrate sufficient day to day awareness of the need to protect people from abuse which posed the risk that abuse may not be identified, or responded to. This was a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had access to the organisational policy and procedure for protection of vulnerable adults from abuse, which was included in the handbook given to each care worker. As the service provided care and support to people living in two boroughs in north London we looked at whether the service knew who to contact if concerns arose and found that they had this information. We asked staff about how they would recognise any potential signs of abuse. The care coordinators we spoke with said that they had training about protecting vulnerable adults from abuse and were able to describe the action they would take if a concern arose. However we were concerned that care workers we spoke with seemed to have limited awareness of this when we asked about what they would do.

We recommend that the service seeks advice and guidance from a reputable source about risk assessments clearly showing the general common potential risks considered and identify what is, or is not, specifically relevant to each person.

The agency had recently introduced a new care planning format. Seven of the ten records we looked at had been transferred to this format which included an assessment of risks for the person receiving care and information for staff. In the care plans we looked at, few risks associated with the care to be delivered were described. We were told that this was because there were few risks involved, although if this was the case it was not actually stated.

The service had arrangements in place to deal with emergencies, whether they were due to an individual's needs, staffing shortfalls or other potential emergencies. We were told by staff that they operate a 24 hour; 365 days per year on call service. People we spoke with who used the service told us they had not experience any difficulties with contacting the agency or having the care staff that they or their relative needed. Staff at the service were able to describe how the on call system worked and we found that this was operating effectively.

The service was not responsible for obtaining medicines on behalf of anyone using the service. The need for care staff to prompt the person to take their medicines was clearly set out within the care plans, which had been agreed with the person or their representative in question. The log books which recorded the care delivered showed that people who required prompting to take their medicines had been reminded by the staff providing care. None of the files we looked at showed that staff were required to support a person in physically taking their medicines. The provider had a policy and procedure in place and the care co-ordinators were able to talk us through this.

Requires Improvement

Is the service effective?

Our findings

The people we spoke with felt that staff were suitably skilled to provide their care. However, one person believed that care staff should know more about diabetes as they had to explain things to staff although they did not think they were at risk, more frustrated at having to repeat their explanations.

People using the service were usually satisfied with the way in which their care was reviewed and how they were consulted. We were told "every time they are on the phone to see if all is okay and if there is anything I need" and people also told us that the service offers regular reviews of care.

The agency had detailed policies, procedures or information in relation to the Mental Capacity Act 2005 (MCA). The provider informed us that they were aware of three people using the service who were subject to enduring power of attorney and their families had gone through the procedures of the court of protection to apply for this authority. It should be noted that the agency would not have responsibility for making applications under either of these pieces of legislation; however, they would have responsibility for ensuring that any decision on the MCA 2005 were complied with. Care staff we spoke with demonstrated little or no understanding of these areas.

We recommend that the agency seek guidance from a reputable source to ensure that staff have an increased awareness of the policies, procedures and information in relation to the Mental Capacity Act 2005 (MCA).

We spoke with the registered manager who explained the system used by the provider for both mandatory and optional training courses. We found the mandatory training covered core skills and knowledge for staff and induction training was in line with the Skills for Care Common Induction standards.

The staff training records we viewed showed that most staff had core training and updated training at periodic intervals. This training was provided by suitably experienced staff working at the service, external training providers and a local authority. This meant that staff were supported to develop the skills and knowledge required to provide the most appropriate care for people, however the training was not effective in some areas, for example safeguarding. We looked at the training records of ten care workers. We saw that in all cases, mandatory training had been undertaken. The staff training records also listed the dates by which refresher training had to be undertaken and this supported the provider's aim to ensure that people were only supported by staff with the necessary skills. Staff told us that they felt that training opportunities provided them with the knowledge they needed to provide care and support although some thought at times this could go further.

We talked with the manager and care coordinators about how staff were supported. We were told that they were in regularly contact with care staff, although in some cases care staff told us this could be more frequent in their view. Staff told us "I get supervision every three months- talk about any concerns or problems, career development, possible improvements", "I had a supervision session this week, and it's every few weeks. I can bring up worries, focus on care and practicalities of role" and "supervision consists of checking your logs/records every few months".The service acknowledged that staff individual supervision was difficult to arrange. We found from looking at staff supervision records that this was patchy and more was required to ensure consistent support for staff. We were, however, shown an instruction letter that had been issued to all staff reminding them that it was expected that they would attend supervision meetings as a part of their employment with the agency.

The provider had a policy that stated annual appraisals occurred. Staff told us "I had appraisal I think a couple of months ago, we looked at looked at changes necessary, whether there is any stress and how the agency can help" and "Someone called me this week to come in and have one but I had one in November. I told them I'd already had one." We found that staff appraisals were usually occurring annually for those working more regularly with the agency but the agency accepted that this was not happening in all cases. The manager informed us that 80% of all staff employed by the service had an appraisal with the last twelve months. We were informed that the service was aware that improvements were necessary, and for staff to have a development plan arising from an appraisal system.

We asked staff how they ensured that people received the care they required. Staff told us they had a rigorous system in place with field assessors who routinely spot checked the work of individual carers. Each person's care was checked at least annually and more regularly if there were

Is the service effective?

specific concerns. Staff told us that each person also received a quality assurance phone call each year to obtain direct feedback about their care. We saw reports of the outcome of these phone calls and noted that recent changes to the format of the reports extended their purpose to include review the adequacy of the level of care and potential changing needs as well as checking that current care instructions were being properly carried out. We saw evidence that these reports had informed changes to the care plans. The care plans that we looked at showed that consent to care and support was being obtained.

In the three care plans we looked at which mentioned the need for staff to support a person with their food, we saw that people that people had been involved with decisions about the food they ate and their preferences were clearly set out. For example one person's plan clearly stated that they preferred coffee and Lucozade rather than tea and other soft drinks.

The service did not have primary responsibility for ensuring that health care needs were addressed. However, the service required that any changes to people's condition that were observed by staff when caring for someone were reported to their relative or the agency. We discussed this with staff who told us that most people were in touch with a range of other health professionals who could alert the provider of any concerns and carers were also required to report in any concerns about the person they observed.

Staff showed us electronic records of phone calls and emails from carers about the people they were supporting and we asked for assurance of follow up to issues we saw carers had identified from the log books. We were able to see evidence that carers had called the agency office to report concerns and care needs were followed up. For example in one record we saw that a carer had noted a person's need for a safety pendant in case of a medical emergency. We saw that this had been taken up by the provider with the appropriate agency and the pendant had been provided. In another example we saw that a carer had phoned their manager to report their concern that a person was cancelling their hospital appointments. The records showed that the provider had contacted the person's GP and informed social services. This showed that people were supported to maintain good health because the care provided was routinely monitored and reviewed. The provider informed other care agencies as appropriate when there were concerns about changing health care needs.

Good

Is the service caring?

Our findings

The people that we spoke with were satisfied with care staff. We were told they are "very caring and treat as a respectable individual ", "they ask for permission and consent all the time, they really care for (my relative) very well" and "they are very caring, they have compassion and are polite." This was the general feeling of the people that we spoke with as they all echoed the same sentiments and said they or their relatives were treated as individuals and with dignity.

The care plans we looked at drew attention to individual needs such as how people communicate, their cultural identify and first language. The new care plan format encouraged a short pen portrait of the person to be included as part of the information available to care staff, and we saw examples of these which included how people preferred to be addressed and their preferences for the way they liked to be cared for. This helped to provide information which assisted carers to form a good rapport with the people they supported.

We saw from the log books that people received their care and support from the same care staff most of the time. The records showed that the same two or three care staff delivered a person's care. This meant that they knew the needs and preferences of the person they cared for and would be able to build up a good relation with them.

We noted that the provider had identified the need to ensure staff providing care understood the culture and background of people using the service. We saw that special training was provided to staff to enable them to appreciate how their own way of communicating may be perceived by people from different backgrounds. This showed that the provider made efforts to ensure staff were able to communicate with people using the service in an appropriate manner.

We saw that many of the people or their representatives had signed to say that they had been involved in discussions and decisions about their care although this was not consistent across all the files we looked at. Staff told us that each person received a comprehensive file of information about the services available by the provider and what they could expect about the provision of their care. Staff told us that this information was explained to each person at the start of their care, which from the comments made to us by people using the service was confirmed. We looked at this information and found that it was comprehensive and clearly presented. We noted that information was also displayed in 23 different languages telling people how to obtain this information in a translated format if English was not their first language.

Good

Is the service responsive?

Our findings

Everyone we spoke with was confident that any complaints or concerns were dealt with in a timely manner. “I am really happy with this service” and “when I complained and requested changes… they took it on board and they started sending the same person, she is excellent.”

We looked at the complaints record and found that 36 complaints had been made in the last year. The manager informed us that most of these had been about communication with the agency and about confusion over when carers were expected. We saw that the complaints had been resolved with no further complaints being escalated. In order to resolve the issues that were raised in these complaints the service had implemented an action plan. This was for all office based staff to complete Diploma 3 in business administration in health and social care and had divided the branch into patches according to post codes providing specific coordinators and field supervisors for each patch. We saw that these changes had been communicated in writing to everyone using the service and staff.

The care to be provided by staff supporting each person was very clearly set out in all the files we looked at. This included information about people's preferences and individual needs. For example the times when carers were to call at people’s homes to deliver care was clearly stated along with the numbers of carers required. Details of what staff needed to do on each visit were clearly described and people we spoke with raised no concern about not being given the care they expected.

We saw from the log books which recorded the care given that we looked at that care was provided in line with these instructions. The log books showed that people were cared for by the same carers most of the time. This helped to ensure staff knew how to support a person and to build up good relationships.

We asked staff how they ensured that people received the care they required. Staff told as they had a rigorous system in place with field assessors routinely spot checking the work of individual carers. Each person’s care was checked at least annually and more regularly if there were specific concerns, which we found to be the case on the care plans that we looked at, for example changes to the times staff visited and additional staff being available at certain times to provide assistance.

All of the staff we spoke with talked about people who used the service in a polite and respectful way. They also told us they believed that it was vital for the service to build and maintain positive and open relationships with those they supported and their families. From these conversations we were left with no concern about the attitude of staff towards those who used the service.

Requires Improvement

Is the service well-led?

Our findings

People had been asked for feedback or for surveys to be completed. We were told "they send a long questionnaire every year or come over to check how we are getting on" and one person told us that they could not recall how regularly this happened but they thought "I am not sure maybe twice a year."

People told us they felt confident to get in touch with the agency if they needed to discuss anything or to raise concerns or complaints and they felt these would be addressed.

The manager told us that they sought people's views at least annually and we saw individual examples of feedback that had been received. However, we were told that there was no other formalised system for carrying out recorded surveys, either regularly or at least annually of staff employed, other professionals in contact with the service or stakeholders in relation to this service, although the provider carried out a general companywide survey. Although people who spoke with us felt able to approach the service with their views, and were surveyed at least annually, we were concerned that a more wide ranging system for seeking feedback which would then feed into a published quality audit and action to be taken by the service did not exist.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told by one member of staff that "the people in the office need training, they are rude sometimes to clients and to care staff", "'I'd go to the manager straight away with any problem- the co-ordinators aren't so competent, they don't pass things on" and "the new manager has really improved things. We have to take the job much more seriously now." Another common theme for care staff was their wish to be able to spend more time with people they cared for. Although when we spoke with people using the service and a relative no one raised any concern about there not being enough time to provide their care.

We recommend that the provider take steps to gather feedback from staff about their overall level of concern about communication between care workers and office based staff to ensure that any communication difficulties which may have a detrimental impact on people using the service be addressed.

Staff told us that each person also received a quality assurance phone call each year to obtain direct feedback about their care. We saw reports of the outcome of these phone calls and noted that recent changes to the format of the reports extended their purpose to include review the adequacy of the level of care and potential changing needs as well as checking that current care instructions were being properly carried out. This was an example of how these reports had informed changes.

A local authority commissioning manager who spoke with us said "the new set of staff and manager have improved things. The organisation and running of the branch has improved. Staff are more supported and morale has improved."There was a clear management structure in place and staff were aware of their roles and responsibilities. Changes had been made recently with the aim to address issues around the structure and co-ordination of the service. The views of people using the service, relatives and other care professionals reflected an increased confidence and trust about the effectiveness of the agency and how it was run.

In discussion with the manager during our inspection we were told about, and shown, the monitoring systems for the day to day operation of the service. Staff had specific roles and responsibilities for different areas and were required to report to the manager about the way the service was operating and any challenges or risks to effective operation that arose.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 11 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** Care staff were unable to demonstrate sufficient day to day awareness of the need to protect people from abuse which posed the risk that abuse may not be identified or responded to.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 10 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** Although people who spoke with us felt able to approach the service with their views we were concerned that a more wide ranging system for seeking feedback which would then feed into a published quality audit and action to be taken by the service did not exist.