London Care Limited

London Care (Brentford)

Inspection report

First Floor
Leeland Road
London
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16 January 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 16 January 2018. We told the provider two working days before our visit that we would be coming because the location provides a domiciliary care service for people in their own homes and staff might be out visiting people.

This was the first inspection of the service since it was registered in June 2017. The service had previously operated from another postal address. This service had been inspected in March 2016 and was rated Good.

London Care (Brentford) is registered to provide personal care to people living in their own homes. At the time of the inspection 181 people used the service. They lived in the London boroughs of Ealing, Hounslow and Brent. The majority of people were older people, and some lived with the experience of dementia. A small amount of younger adults with physical disabilities, people with learning disabilities and people with mental health needs used the service. London Care (Brentford) is a branch of London Care Limited, a provider of 22 homecare services in London and South East England. The provider is part of the City and County Healthcare Group who own and manage a number of care providers.

The registered manager left the organisation in 2017. A new manager had been recruited and they had started the process of applying to be registered with the Care Quality Commission. 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 and associated Regulations about how the service is run.

People using the service and their representatives were generally happy. They liked the regular care workers who supported them and they felt their needs were being met. People told us the care workers were kind, considerate and friendly. Some people felt that visits did not always take place at the time they expected. Whilst some people said they did not mind a degree of flexibility, others felt that the care visits were sometimes so late that it disrupted their day and how they would like to be cared for. Most people explained that late visits were not a regular occurrence. People also told us they were not always informed when their care worker was running late so they did not know what was happening. We discussed this with the manager at the service and looked at the systems the provider had for monitoring when visits were planned and took place. The system had improved in recent months and the provider had an effective process for

identifying and responding when visits did not take place as planned.

People told us they were involved in planning their own care. They said that their choices were respected and that the care was delivered in a way which supported them to stay as independent as they wanted. We saw that assessments of needs and care plans were clear and well designed. People had consented to their plans where they were able. For people who did not have capacity to consent, the provider had made sure that care was planned in their best interests with their representatives. The care plans included information about individual preferences and had been updated when people's needs changed.

The care workers who we spoke with gave us mixed feedback on their experiences working for the agency. Some care workers told us they did not always feel supported or have the training they needed. They also told us they were not allocated enough travel time between care visits. We looked at records of staff training, supervision and support. There was evidence that the staff had regular and thorough training and that they had opportunities to meet with their manager to discuss their work. The provider also carried out regular spot checks to observe how the care workers were supporting people and assessed their competencies with key tasks.

The provider had processes designed to keep people safe and help protect them from abuse. The risks each person was exposed to had been assessed and planned for. People received their medicines safely and as prescribed. The staff were aware of how to recognise and report abuse and had responded appropriately in instances where they had been concerned about someone's wellbeing. The provider had a contingency plan for different emergency situations and the staff knew how to respond in order to make sure people were safely cared for.

People using the service, their representatives and the staff were able to feedback their views and opinions about the service. The provider regularly asked people for this feedback. Complaints were appropriately investigated. There was evidence the provider had learnt from these and made changes which reflected best practice and how people wanted to be cared for. The provider worked closely with the local commissioning authorities and had responded to requests from them for changes. They also had their own systems for auditing the service. We saw that these were effective.

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 using the service and their relatives felt safe.

There were systems, processes and practices designed to safeguard people from abuse.

The risks to people had been assessed and their safety was monitored.

There were sufficient numbers of suitable staff employed to meet people's needs and keep them safe.

People received their medicines as prescribed and in a safe way.

People were protected by the prevention and control of infection.

The agency had systems for dealing with different emergencies and learning from mistakes.

Is the service effective?

Good

The service was effective.

People's care needs and choices were assessed in line with good practice guidance and legislation.

People were cared for by staff who were well supported, trained and supervised.

The provider worked within the principles of the Mental Capacity Act 2005.

The provider worked with other professionals to support people to lead healthier lives.

People were supported to have enough to eat and drink.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion.

People were able to express their views and be involved with making decisions.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People received the care and support they required to meet their needs.

People knew how to make a complaint and felt that they were listened to.

Is the service well-led?

Good

The service was well-led.

The agency had a clear vision and strategy to provide high quality care and support.

People using the service and other stakeholders were invited to share their views about the service and these were listened to and acted upon.

There were appropriate systems to assessing, monitoring and improving the quality of the service.

London Care (Brentford)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 16 January 2018. We told the provider two working days before our visit that we would be coming because the location provides a domiciliary care service for people in their own homes and staff might be out visiting people.

The inspection visit was carried out by one inspector. Before the visit we contacted people who used the service and their representatives and care workers by telephone. These telephone calls were carried out by an expert-by-experience and a second inspector. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at all the information we held about the service. This included the information we had about the branch when it operated at another address, feedback from the local authority, safeguarding alerts and statutory notifications about significant events.

During the inspection we spoke with 16 people who used the service and the relatives of five different people by telephone. We also spoke with 10 care workers by telephone.

When we visited the agency we met the new manager, who had started at the branch on the day of our inspection, a regional support manager who had been overseeing the management of the branch and two company directors. We looked at the care files for six people who used the service, including records of care provided. We also looked at the recruitment, training and support records for six members of staff, records of complaints, quality monitoring systems, meeting minutes and some policies and procedures.

Good

Our findings

People using the service and their relatives told us that they felt safe with the care workers who visited them. They said that they trusted their regular care workers. The agency supported some people by undertaking shopping for them. People told us that they were happy with this service. We saw that the staff kept records of the money they had spent and people who were able to had signed their agreement with these records. The agency audited financial transaction records regularly so they could identify if anything had been wrongly recorded or any concerns with the way in which the staff spent people's money. Part of the agency's induction training for staff included how to support people in this area and information about financial abuse.

The agency had procedures for safeguarding adults and whistle blowing. The staff received training about these as part of their induction and in annual updates. We saw that recognising and reporting abuse were also discussed at regular team and individual meetings with the staff. The staff who we spoke with had a good knowledge of the safeguarding procedures and were able to tell us how they would report suspected abuse. The agency had responded appropriately to safeguarding alerts, working with the local safeguarding authorities, police and others to help protect people and to investigate any abuse. They had clear records of action taken and had notified the Care Quality Commission as required.

The risks to people had been assessed and their safety was monitored. The agency had carried out thorough assessments of individual risks relating to people's health, skin integrity, nutritional risk, assisted moving, falls, equipment and their home environment. The agency also undertook assessments of fire safety in people's homes. The assessments detailed where risks were identified and the action the staff should take to help keep people safe. These were regularly updated and reviewed. Where people had capacity they had been involved in the assessments and had agreed to these.

The staff received training about recognising and responding to different risks during their induction and then again at annual training updates. The agency carried out regular quality monitoring visits and calls, as well as visits to observe the care workers supporting people. As part of these processes the agency considered how risks were being managed and whether people were being safely cared for.

There were sufficient numbers of staff employed to meet people's needs and keep them safe. The manager told us that the agency did not accept referrals to care for new people if they did not have the staff available to care for the person. The staff worked in teams based in geographical areas so that travel time between visits was minimised. People were usually cared for by the same familiar staff. The agency had systems for

planning how care visits were allocated and the time of each visit. This electronic planning and monitoring system had recently been updated and improved. One member of staff was employed to monitor the system continuously so they could identify if care workers were late or did not arrive for a visit.

People we spoke with gave us mixed feedback about whether visits took place on time. Some people expressed concern and told us that visits were sometimes up to two hours later than planned. However, the majority of people told us that care workers usually arrived on time or that they did not mind the small variations in the time of visits which they had experienced. For example some of their comments included, ''They are sometimes a bit late, some let me know'', ''I have the same carer and she arrives on time. She does everything in the time", ''[My care worker] is somebody I can trust and she knows me'', "They come on time and leave after the right amount of time'', ''Our regular carer is very good, the problems are mainly at weekends, they are sometimes very late at weekends'' and ''They are not always on time, sometimes I telephone them, the regular ones know what to do but the problem is the new ones.'' People told us that if the care workers were running late the agency did not always let them know. Some said they could not get hold of anyone in the agency offices when they tried to ring.

The care workers who we spoke with told us that they felt they did not always have enough time to travel between visits and they thought this was because the agency was short of care workers.

We checked records of care visits. We looked at log books where the staff had recorded details of the visits. These books included some visits in November and December 2017 as well as some for January 2018. We also looked at the electronic call monitoring for six people using the service and six members of staff for December 2017 and January 2018. We said that generally visits took place at the same planned time each day. The log books for two people included some inconsistencies around the timing of visits. For example, over a two week period one person's lunch time visit varied between 12pm and 15.20pm. The person's morning visit also had a variation of up to two hours. Another person had a similar experience with their evening visits varying between 15.20pm on one day to 18.20pm on another day. We discussed these with the manager who said that improvements in scheduling and time keeping had occurred in the last month. The electronic call monitoring records confirmed this with evidence that care visits mostly took place at the same regular time each day. However, in one instance a person's scheduled visit for 7am was regularly carried out at 6.15am by the same member of staff. The manager told us that, apart from 24 hour care packages, the visits were not due to start until 6.30am at the earliest. Therefore the agency may wish to consider speaking with the staff concerned about any discrepancies and the appropriateness of waking people 45 minutes before they expected their visit.

We noted that in both log books and the electronic records that care visits lasted for the right amount of time and even when care workers arrived late they had stayed for the correct duration. We noted that care workers were allocated travel time between visits on their schedules.

The agency carried out suitable checks when employing staff. Staff attended a formal interview at the agency offices and this was recorded. The staff also completed an application form giving details of their employment history. We saw that the agency had requested information about any gaps in this and these had been recorded. The agency requested evidence of the staff member's identification, eligibility to work in the United Kingdom, references from previous employers and a check from the Disclosure and Barring Service regarding any criminal record. In instances when a staff member declared a previous criminal conviction the agency undertook a risk assessment on their suitability. These assessments were considered by senior managers and included plans to reduce the risks to people using the service for any such staff who were employed. We viewed a sample of these assessments and found them to be comprehensive and appropriate.

People received their medicines as prescribed and in a safe way. People who were supported with this aspect of their care told us they were happy with the support. Each person's care records listed the medicines they were prescribed and any support they needed with these. The agency had created a medicines risk assessment which outlined any risks associated with medicines. People had consented to the staff administering medicines. There were clear administration charts which the staff completed. These were checked by the agency and any discrepancies were investigated. The manager told us that where the staff had failed to administer medicines as prescribed or to record this then action was taken which may include retraining, reassessment or disciplinary action.

The staff undertook training in the safe handling of medicines and this was assessed during their induction and annually. The agency carried out observations of the staff handling medicines and these were recorded.

People were protected by the prevention and control of infection. The agency had procedures regarding infection control and the staff received training in these. The staff were provided with protective equipment, such as gloves, aprons and hand sanitiser. The staff were able to give us detailed information about infection control procedures and how they could help prevent the spread of infection. The agency's spot check observations of staff included checks regarding hand hygiene, use of protective equipment and providing people with appropriate support to minimise infections.

The agency had systems for dealing with different emergencies. Managers took it in turns to provide out of office hours' telephone support for staff and people using the service. The electronic call monitoring systems could be accessed during these times. The agency had a contingency plan regarding how they would deal with different situations which disrupted the service. People at high risk because of their condition, lack of family support or time specific medicines were highlighted so that any problems with them receiving care as planned were identified and acted on immediately.

The staff recorded all accidents, incidents and complaints. The agency had systems for learning from these. For example following an incident, this was discussed with the staff involved and also other staff where relevant so that they could learn from these. This process went beyond the confines of the branch and all staff working for the provider were given the opportunity to learn. The directors told us about an incident which had occurred in another branch where someone choked. As a result a training webinar had been set up for all senior staff members. The training department had created information for all staff and this had been shared through branch team meetings and individual staff supervisions.

Good

Our findings

People's care needs and choices were assessed in line with good practice guidance and legislation. The majority of people were referred to the service by local authorities. The agency received an assessment of needs from the local authority and used this to make an initial judgement about whether they could care for the person. The agency then carried out its own assessments. The agency used recognised good practice formats for assessing people's nutritional risks, skin integrity, assisted moving and making judgements about their capacity. In addition, the agency had assessed people's individual care needs and the specific interventions required from the agency. These assessments were well documented and there was clear evidence that people had been involved by expressing their views and wishes regarding the service. The agency carried out reassessments at regular intervals and when changes occurred, for example following an accident or hospital admission.

The care records included NHS guidance on the conditions which affected people, for example, stroke, diabetes, Parkinson's disease, learning disabilities. The NHS guidance was designed as and information tool to support the staff to understand about good practice in caring for people. In addition, the agency cross referenced the guidance to make sure they had carried out the correct assessments for each person's needs.

People were cared for by staff who were well supported, trained and supervised. New staff completed a five day training course at the agency offices in which they were required to complete work books to demonstrate their understanding. The training was provided in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. We found that the training provided by the agency was comprehensive and included specific guidance and training on a range of health conditions as well as systems and processes. Staff were assessed by a qualified trainer and again in the work place by senior staff. Training updates were provided annually in all areas. The manager told us that the branch worked closely with the training department to request additional training if needed. For example, if a person had a complex need or required support to use a specific piece of equipment. The branch had a training room which was well equipped and included posters with guidance and information. Smaller versions of these posters were provided for the staff as quick reference guides to accompany different learning.

Some of the staff we spoke with had transferred from other agencies which had ceased to exist. The provider had followed the appropriate legal processes for transfer. We spoke with some of these staff and they told us they did not feel they had been offered training with the agency when they transferred. We discussed this with the manager. The records of staff training indicated that all staff, including those who had transferred

from other agencies, had been offered regular training opportunities.

All of the staff who we spoke with were able to describe the training they had received and also had a good knowledge of different areas of practice which we asked them about.

Some of the staff told us they did not feel supported by the agency and did not have the information they needed. We looked at records relating to this and found that the agency had offered a range of information for staff including a handbook which contained key policies and procedures. There were regular staff meetings which included discussions about practice and guidance. In addition all the staff had taken part in recent individual meetings where they were given the opportunity to discuss how they felt about work and any concerns they had. These were recorded and we saw that staff had generally given positive feedback in these meetings and had also received praise for the good work they had undertaken. There was evidence that staff who had been employed for over one year had taken part in an appraisal where they could discuss how they wanted their career to progress. In addition the agency organised themed supervisions where they discussed a specific topic with a staff member. We saw records which included topics such as skin integrity, continence, communication and record keeping.

The agency undertook spot checks where senior staff observed care workers providing care and support to people. These included a range of observations and feedback from the person receiving care.

The manager told us that the branch was well supported by senior managers within the organisation and that there were good systems for sharing information and practice discussions.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The agency had carried out assessments of people's capacity. We saw that where people had capacity they had been asked to consent to their care plans and assessments. Where they were able to sign they had done and for people who had given verbal consent this had been recorded. People told us that the care workers offered them choices and gained their consent at all visits. The care workers demonstrated a good understanding of the MCA and knew that they had to obtain consent before providing care.

Some people did not have the capacity to consent. The provider had acted appropriately and worked with others to make sure decisions were made in people's best interests. In instances where people had an assigned Power of Attorney, the provider had requested and obtained information relating to this so that they knew who was legally responsible for making decisions. Care plans included information about how the person communicated and mechanisms which could be used to support the person to understand and make decisions.

The agency recorded information about people's healthcare needs and any healthcare professionals who were involved in supporting the person. We saw that care plans included specific guidance relating to healthcare conditions. Logs of care provided included information about people's wellbeing and there was evidence that the agency had responded appropriately to changes in people's health by contacting the relevant health care professionals.

People who were supported with meals were happy with this support. They told us that care workers provided them with the meals of their choice and that food was prepared well. Information about people's dietary needs, including the assistance they required was recorded in care plans. The care workers recorded the food they had provided and how much people had eaten.

Good

Our findings

People told us that the care workers were kind, compassionate, caring and they had good relationships with them. Their comments included, ''[My care worker] is a real gem'', ''They are very kind and caring'', ''My regular carer is lovely'' and ''They are like friends to me and it makes me smile when they come each day.''

The care workers received training about caring for people in a compassionate way and this theme was also discussed during team and individual meetings. The care plans included information about people's choices and how they wished to be cared for. The logs of care provided showed that the care workers had followed these wishes when delivering care. The care workers had used language which was respectful and considerate of how the person felt.

People using the service and their relatives told us that the care workers respected their privacy. For example, some of their comments included, ''They usually close doors when they are washing and changing her; yes, they do protect her privacy'', "They [care workers] stand outside the door and wait for me to finish'' and ''The carers always cover me up.''

The care worker induction training included a module regarding privacy and dignity using a case study to help the care workers to think about this aspect of their work. The care workers we spoke with showed understanding with comments such as, ''You have to be very patient, adapt the way you work", ''Despite what your own beliefs are, when you go into your service user, I put my professional head on and respect their home and their beliefs" and "I always try to help my service user to make their own choices if they have memory problems." The care plans included information about people's social history, religion and culture, including guidance for the staff on how to respect these.

People told us they were involved in planning their own care and that their views and choices were respected. We saw evidence of this with information about personal preferences recorded. Some of the comments from people included, ''[My relative] does not speak but the carers always speak with [them] and make sure [they] feel comfortable and are happy with what they are doing'', ''They are really good at offering choices'', ''They allow me to be as independent as I want and help me with the bits I can't do.''

Good

Our findings

People using the service and their relatives told us that the agency met their needs. They explained that they had been involved in planning their own care and that the care workers followed the agreed care plan. People had a copy of their care plan and were happy with this. We saw that care plans included individual preferences and clear guidance for the staff. Some of the comments from people included, ''The carers do what they are supposed to do'', ''I am happy with the care I receive'', ''I did the care plan and they come for a review every year'', ''The care plan is in the book and we know what it says'' and ''I am happy with everything.''

The care records included information about ''Me and my life'', a brief outline of people's social history and interests, goals the person wanted to achieve, how this could be supported and a breakdown of the person's usual routine and how they wished to be cared for with each aspect of this.

Records of care provided showed that the care workers had followed plans and recorded how the person was. We saw that these records were audited by the agency on a regular basis. The agency carried out regular reviews of care and we saw that people had been involved with these. Care plans had been updated when a person's needs changed.

People were usually cared for by the same member of staff. They told us they were happy with this arrangement.

People told us they knew how to make a complaint and had information about this in the records provided by the agency in their home. Some people told us they had made a complaint. They said they were satisfied with the way in which these had been dealt with. However, some people told us they did not always receive feedback from the agency about the outcome.

We looked at the agencies records of complaints. There was evidence that these had been investigated and appropriate action had been taken to resolve the issues and learn from these incidents.

Good

Our findings

People using the service and their representatives were generally happy with the service. However, some people commented that communication with the office staff needed to be improved. Some of their comments included, "I feel it's good but it needs to be better in their timings and communication between the office and families'', ''They are good at doing the little things like helping [my relative] choose [their] clothes'', "It is a good service. They try their best and they help me very much'', ''Just tell them to keep sending me the same care worker and not to change'', "The service is satisfactory for me but I can't speak for anyone else", "I feel it's a good service. This carer is well-mannered and she's respectful'', ''It is not too bad'', ''Sometimes at the weekend the carers do not arrive and we cannot get hold of the office'', ''It is a good service, my carer is sensitive and does not judge me'' and ''If someone is on leave they do not tell us about the change of carer.''

The care workers who we spoke with told us they liked their jobs and caring for people. Some of them did not feel supported and felt concerned about changes in management. Some of their comments included, "I like my job, but it is very tiring", "Managers keep leaving, I don't know why, but they do'', "I like helping people, I enjoy it, some of the people I visit have no family and look forward to my visit, I might be the only person they see", "I like to brighten their day if I can'', "I know my clients very well, they like me, I know their ways and how they like things done", "I am very happy now, I don't have any problems I just get on with my job" and "I enjoy my job and the flexibility."

The agency's aims and objectives included providing person centred care and support. People were asked for their views regarding their care on a regular basis. We saw evidence that the agency visited people and contacted them by telephone for their feedback. The feedback we saw indicated people were happy with the service. Some of the comments the provider had received from people using the service in recent months included, ''I am very happy with the carers'', ''Overall I am happy'', ''I am happy with the service and the carers are doing a great job'' and ''The carers go above and beyond with care.'' The agency had a system where they wrote to individual care workers when they had received positive comments about their work. Some of these commendations of staff included explaining that they were, ''Helpful, caring, honest polite, kind'' and in one instance ''The best carer [person] had ever had.''

There was a clear management and senior management structure at the branch and within the agency. A new manager had been appointed to the branch and had started the process of applying to be registered with the Care Quality Commission. They were undertaking a vocational qualification in care management and had been previously working in senior roles for the agency. They were being supported by a senior

manager who had previously been a registered manager. The branch had good systems for communicating and mitigating risks. For example, senior staff met each week to discuss the service, including areas of risk, quality visits, reassessments and staff supervisions which needed to take place. Work was allocated according to the needs of the service between the managers and senior staff. We saw that these systems worked well.

The senior staff audited all care records, medicines administration charts and financial transactions. We saw that discrepancies had been highlighted and acted upon with staff being asked to explain what had happened. The agency employed a person whose role was to oversee the electronic call monitoring system. The manager told us that since this person had been appointed there had been a reduction in missed or late visits and communication with people about care workers running late had improved.

The regional managers visited the branch regularly to offer support and guidance. The manager told us that this was helpful. The agency also employed their own compliance manager who undertook audits of the files and created an action plan where improvements were needed.

The manager had worked closely with the local commissioning authorities and in one instance had created an action plan to demonstrate how they would make improvements requested by the authority. The manager also told us that they worked with other branches and companies working under the City and Country Healthcare umbrella to share training, ideas and good practice.

The provider was in the process of trialling new electronic care plans in other branches and was considering how they could use technology to improve the way they planned and recorded care across the agency.