Miss Margaret Anne Morrison

Trust Life Care

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Trust Life Care on 28 September, and 2 and 4 October 2018. We gave the provider 48 hours notice to make sure someone would be in the office. At our last inspection we rated the service as requires improvement, with one breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the service had made the required improvements and was no longer in breach of the regulation.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults.

Not everyone using Trust Life Care receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager in post at the time of the inspection. 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.

Everyone we spoke with felt the service was safe. Staff had received training in safeguarding vulnerable adults and were able to describe how they would protect people from harm. In one instance we saw how staff used a process to protect someone from financial abuse.

There were enough staff to meet people's needs. There were no missed visits and people told us staff were generally on time and punctual. At the time of the inspection, the service was recruiting new staff due to absence and staff who had left. The service was using two regular agency members of staff and had recently recruited a deputy manager and care worker.

Medicines were managed safely. Staff received training and competency assessments before they helped people with their medicines. Where necessary, staff received specialised training to meet the needs of people who required support with more complex medicines. Medicine administration records were well written and notes from staff demonstrated good medicines knowledge.

Staff received training, and people told us staff were competent to meet their needs. Staff told us they felt well supported through induction and supervisions.

People were supported to eat and drink enough to maintain their wellbeing, and staff were knowledgeable about people's dietary preferences. Staff recorded people's food and fluid intake where necessary. Staff also worked in partnership with other health and social care agencies to monitor people's health.

People and their relatives gave positive feedback about staff's attitude. They told us staff were kind and caring. We observed good interactions between people and staff. Staff knew how to protect people's privacy and dignity, and people we spoke with said staff were sensitive to their needs and feelings.

Care plans were written in a person centred way with good detailed information on how to meet people's needs. Care plans were reviewed either annually, or in response to a change in need such as decline in mobility, or other necessary reason.

The service had not received any complaints since our last inspection. There were policies and procedures in place, and people told us they were confident they could raise any issues they had.

The service did not always manage records well. We found the training and supervision matrix were out of date, and a quality assurance file was missing. However, staff we spoke with felt well supported and there was other evidence which demonstrated staff training was up to date. We have made a recommendation about the management of records.

The service had improved its quality monitoring arrangements. Audits of medicine administration records were effective, as we noted improvement in the quality of medicines records at this inspection.

The service did not conduct formal feedback for people using the service, however the registered manager often delivered care in person and people told us they could always go to them with any issues they had.

Staff told us there was an open culture and the registered manager was approachable. Staff recommended the service as a place to work or receive care.

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.

Staff were recruited safely and there were enough staff to meet people's needs.

Medicine administration was safe, and notes in medicines administration records showed good staff knowledge.

Staff received training in safeguarding vulnerable adults, and were able to describe how to keep people safe.

Risk assessments gave clear guidelines for staff on how to avoid risk. Staff had been trained in preventing the spread of infections.

Is the service effective?

Good

The service was effective.

Staff received an induction and training in a variety of areas. Staff told us they received good support through supervisions and spot checks.

People were supported to maintain a healthy diet and their physical health was monitored in partnership with other healthcare agencies.

The service was operating under the principles of the Mental Capacity Act (2005).

Is the service caring?

Good

The service was caring.

People and relatives we spoke with said that staff were kind, caring and compassionate. We observed staff had a good rapport with people they cared for.

The service promoted and protected people's privacy and dignity. People said they felt staff helped them maintain their dignity when they might otherwise feel embarrassed.

The service took into account people's diverse needs. Staff prompted people to make choices for themselves so they could retain as much independence as they needed.

Is the service responsive?

Good

The service was responsive.

Care plans contained good person centred information on how to care for people in the way they wanted. Care plans were regularly updated to reflect changing needs.

Care plans contained information about people's life histories, social network and interests.

There were no complaints made to the service, however people told us they were confident they could follow the complaints procedure if necessary.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Records were not always managed appropriately. Training and supervision records were not up to date, and some quality assurance information was unavailable.

Although staff felt supported and that the registered manager was approachable, the service did not conduct staff meetings. People felt the registered manager was approachable, however we did no see evidence of how people's views were sought and acted upon.

The service had made improvements in its quality monitoring processes. Medicine administration records and care plans were audited regularly for effectiveness.

Trust Life Care

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 announced inspection took place on 28 September, and the 2 and 4 October 2018.

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. At the time of the inspection there were 29 people using the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
Prior to the inspection we gathered feedback from the local authority commissioners, and reviewed statutory notifications sent to us by the provider. These are notifications of significant events providers are obliged to send us.

The inspection was carried out by one adult social care inspector. During our inspection we spoke with three people who used the service and two relatives of people who used the service. We also spoke with five members of staff including the registered manager and care staff. We reviewed documents relating to people's care and other documents relevant to the running of the service. This included four care plans, five staff personnel files, risk assessments, quality audits and training records.

Good

Is the service safe?

Our findings

At our last inspection in August 2017 we found that medicines were not always managed safely. Records showed staff did not always sign medicines administration records (MARs) to show that medicines had been given and there were often missing signatures or gaps in documents without explanation. We concluded this was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulations 2014) Regulated Activities. At this inspection we found the service had made the required improvements and was no longer in breach of the regulation.

We reviewed MARs and found that staff recorded detailed information and demonstrated an awareness of medicines safety. For example, one member of staff had noted, 'Lunch medicine (paracetamol) not given as not enough time elapsed since morning medicine'. On another MAR, staff had noted the person had refused their medicine. As an action, the next member of staff visiting that day was instructed to offer it and did so successfully. We saw an instance where a prescribed skin cream was shown as not given because staff had written that the person was smoking and the cream was flammable, therefore it would have been unsafe to administer the medicine. This meant that missing signatures in MARs had reasonable explanations documented by staff, and actions were followed up. MARs contained sufficient information on the medicines, their method of delivery and their side effects. Care plans contained information on people's medical allergies.

We observed medicines administration and found this to be safe. Staff were knowledgeable about medicines management. Where one person had a percutaneous endoscopic gastronomy tube for feeding (a tube inserted through the skin to allow food and medicine to be passed directly into the stomach) staff received training from an accredited third party organisation. Only those staff who had been trained were allowed to administer medicine to that person. Staff competency was checked before they were allowed to administer medicine without support. Staff received annual training in medicines administration.

All people and their relatives we spoke with told us they felt the service was safe. One relative we spoke with said, "[Name] is in safe hands. No hesitation."

There were enough staff to meet people's needs and there were no missed visits as a result of staffing levels. The service was in a period of recruitment. One member of staff said, "Since I've started a few have left but we are getting there. My route is just the same. Peoples needs are being met. The registered manager comes and does calls themselves`." The service was using two regular agency staff while recruitment was ongoing. The registered manager received a profile of prospective agency staff members with information on their training and criminal background checks. The service had recruited a deputy manager and a care staff member however they had not started their induction at the time of the inspection. The registered manager told us they anticipated this would reduce staff pressures.

We reviewed three staff personnel files and found that staff were recruited safely. This included photographic identification an ,interview, professional references and a disclosure and barring service (DBS) check. The DBS is a national agency which uses the police national database to help employers make safer

recruitment choices.

Staff received training in safeguarding vulnerable adults. Staff we spoke with were confident they knew how to identify and report signs of abuse. One staff member said, "It could be if I found people had been given medications in the wrong way, or noted missing medications in the records. If I saw something like that I'd just go straight to the registered manager, or CQC." Another member of staff said, "There was one person and we noticed changes, they started to become withdrawn so that automatically raises alarm bells. I just informed the registered manager."

Risks to people were assessed appropriately, in a person centred way with clear directions for staff on how to avoid risks. For example, in one person's environmental risk assessment there were photographs of all key utility points so staff could easily locate them in the event of an emergency. We saw there was a financial risk assessment for one person who was at risk of financial abuse, with instructions for staff to take copies of all receipts and have them countersigned by senior staff when essential items had been bought for them. Records showed staff complied with this. People had personal emergency evacuation plans with information on how to evacuate them safely in the event of a fire. There was a business continuity plan in place which included a scheme of delegation and actions to take in the event of a catastrophe or serious event, such as a power cut or extreme weather event.

Accidents and incidents were reported and investigated appropriately. We saw one incident where a person had fallen and used their falls alarm. Staff attended and the investigation found staff had acted appropriately.

Staff received training in preventing the spread of infection. We observed staff wearing personal protective equipment during a home visit. Staff we spoke with told us there was plenty of personal protective equipment available.

Good

Is the service effective?

Our findings

People we spoke with told us they felt staff were well trained to meet people's needs. One person we spoke with said, "They are well trained. No messing about, been there done that. No problems, I'm happy they come to see me." Another person told us, "The lady we get is very efficient. Well trained to do the job, seems to know about medicines."

Staff completed training the service considered mandatory. Staff told us they felt their training and induction was good. One member of staff said, "With training needs I feel well supported with everything. Every year we do mandatory training. Every year you're due another one the manager tells you." New staff were introduced through 'shadow shifts' with experienced staff. One relative we spoke with said, "If it is someone new there is somebody very competent with them to show them the ropes and where everything is."

The service used a training matrix to show what training staff had completed and when courses were due to be refreshed, however this had not been updated. We have reported on this further in the 'well-led' section of the report. When we reviewed staff files, we found that there were certificates to evidence staff had completed training courses.

The registered manager or care co-ordinator conducted competency assessments and spot checks to ensure that staff had the right skills to deliver care. One member of staff said, "I've had competency assessments with the care coordinator. They make sure you are giving the right medications and things like that."

Staff we spoke with said they felt well supported by the registered manager. One staff member said, "Training is fairly comprehensive, I've still got some to do. It's always good to do it. I've had a supervision and got my appraisal form to fill in." We reviewed a supervision where staff discussed rotas and working hours, medication compliance, policies, reporting concerns and training needs.

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 with the appropriate legal authority. For care services at home, applications to deprive people of their liberty must be made to the Court of Protection.

We checked whether the service was operating under the principles of the MCA. Staff received training in the MCA at induction and as part of training the service considered mandatory. Staff we spoke with were knowledgeable about people's capacity, and where relevant assessments conducted by the local authority

were in people's care plans as guidance for staff. One staff member talked about someone they cared for saying, "I wouldn't say they have the capacity to retain information in the short term because of their condition, but we always offer choice."

People were supported to maintain a healthy, balanced diet which took their preferences into account. One person's care plan read: 'For breakfast, [name] likes porridge, weetabix with warm milk and honey, or toast and marmalade with a warm drink. Staff must feed [name] every meal and drink. Do not leave [name] with plated or a dish of food.' Where necessary, staff recorded people's food and fluid intake.

The service closely monitored people's health, and worked in partnership with other health and social care agencies to ensure important information was shared, and new processes implemented. Important correspondence from GPs and district nurses was included in people's care plans and shared with staff. One relative said, "Yesterday we had both the swallowing nurse and then dietician in the afternoon. The nurse suggested with medication, if they had a separate syringe for each medicine one rather than using one and flushing it out with water each time that would be beneficial. Those are the kind of things they are very good at communicating. There is good communication between the organisations."

Good

Is the service caring?

Our findings

Everyone we spoke with said staff were kind, caring and respectful. One relative we spoke with said, "They are polite and respectful, very friendly. We ask [staff name] to do something, they will do it. No problems." Another relative we spoke with told us, "[Staff name] is a lovely cheery person and does the job well. Nobody is discourteous or rude."

Staff knew how to protect people's privacy and dignity. During our visit we observed staff closing curtains and doors. One relative said, "They always respect that [privacy and dignity]. Very good. They do it by routine, it's in their thinking all the time. They always close the curtains on both sides of the room." One person commented, "What is embarrassing is the toilet. They are very discreet. No problem. They always ask before they do anything. I could never do what they do. I do find them very good." A member of staff we spoke with said, "For privacy and dignity we shut the door, use the shower curtains and when we help people to dry we put towel over their areas."

During our observations people were calm and there was good humour between staff and the people they cared for. One person was visibly at ease in the company of staff and told us good-humoured stories about their care. Staff we spoke with knew people's preferences and details about their private lives which were important in getting to know them and their needs. One member of staff said, "Well, for food and things [name] likes fish from the chip shop, we talk to their visitors and get to know things about them as well as from their care plan. They also get visits from the church."

Staff promoted people's independence by offering them choice so that they would have control over their lives. Care plans prompted staff to offer people a choice over aspects of their lives such as washing and bathing, dressing and food. One care plan read, 'Always ask if [name] would prefer a bath or shower.' A member of staff said, "With food for example I give people loads of choice, and I've taught myself to memorize people's preferences!"

The service recorded people's religious and cultural requirements. In practice this ranged from staff supporting people to eat diets in accordance with their beliefs, for example a person who ate a strictly vegetarian diet, to supporting people who regularly attended religious service's and had a network of church friends who were important to them.

Good

Is the service responsive?

Our findings

We reviewed people's care plans and found they included good person centred and detailed information on how to care for people in a way they wanted. For example, in one person's morning routine it instructed staff to: 'Prompt [name] to bring their legs out of bed, assisting [name] to sit on the edge of the bed. Assist them to stand and walk to bathroom. Encourage [name] to the toilet.' Some care plans contained visual guides, for example one person had pictures taken of them in stages of moving and handling so that staff would have an easy to follow guide to help the person move in a way that was safe and comfortable for them.

Care plans contained personalised information on people's social networks and life history so staff would be able to gain a better understanding of the people they cared for and understand what was important to them, as well as help reduce social isolation. One care plan read, '[Name] lives alone in a privately owned bungalow, and worked in retail all their life. [Name] has always enjoyed reading. They were a member of the church choir and enjoyed amateur dramatics. Their friends from church visit. [Name] suffers from Alzheimer's and requires direction and support with all daily tasks.' Staff told us this information provided a useful direction for conversation and talking about things relevant to people's interests.

Care plans were reviewed annually or in response to changing needs in partnership with people and their relatives. For example, we reviewed one care plan where the review was annual and no changes were required because the package of care was not complex and feedback was positive. We reviewed another care plan where reviews were frequent because of changing and complex medical needs. This meant that care plans were flexible and responsive to people's needs.

Staff understood their roles and responsibilities in delivering care for people at the end of their lives. Care plans contained information from relevant partner agencies such as district nurses and GPs. One member of staff said, "We look after [name] in bed now. When you get to know them you know how they like things done before they even ask."

There was a complaints policy available. The service left blank copies of complaints forms with information on how to make a complaint in people's care plans in their home. Everyone we spoke with told us they felt confident they knew how to make a complaint and would be comfortable in doing so. There had been no formal complaints recorded since the last inspection. One person we spoke with said, "I feel comfortable I could go to the manager. I don't think I've had a complaint." Another person told us, "I've had nothing to complain about but I'm sure I could go to them if I had one."
The service was working under the principles of the accessible information standard (AIS). The AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way people can understand. People's care plans included information about their sensory and communication abilities and what aids they needed to ensure effective communication.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in August 2017, we found that quality assurance systems were not always robust. This was because issues identified in medicines records were not picked up through audits. We concluded this was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the service had made the requirements and was no longer in breach of the regulation, however there were other areas found at this inspection which required improvement.

At this inspection, we found that medicine administration records (MARs) were audited effectively, with issues identified, raised and dealt with appropriately. Staff were using MARs more effectively to communicate where medicines had not been given, or where medicines were discontinued. The registered manager audited daily notes regularly and communicated with staff where they could improve note taking. The registered manager and care co-ordinator conducted regular spot checks to make sure staff were maintaining good standards of practice.

We identified some issues with records management. The registered manager was unable to locate the quality assurance file which contained evidence of survey responses and quality calls. We found the service's training and supervision matrix were not up to date, and were not reflective of staff training or supervisions conducted.
Staff we spoke with told us said they had received supervisions regularly and were well supported, and staff files evidence the completion of training modules. However for two staff their last recorded supervision was in 2017. The registered manager told us the service's policy is that staff receive a minimum of three supervisions each year, yet records of the conversations had not been kept by a previously employed member of staff responsible for this. Through our conversations with staff it was evident supervisions had taken place, and that they received training regularly. However, there was no effective oversight as relevant documents and personnel files were not updated to reflect this.

We recommend the provider review and improve its information governance and record keeping arrangements.

The registered manager told us that they had recently recruited a deputy manager with relevant experience who would help improve records management, however they were not in post at the time of the inspection.

Staff told us the registered manager was approachable, and that there was an open an honest culture at the service. One staff member said, "Its okay. I know I can speak to the manager or the co-ordinator if I have a problem. Management are approachable. You can just ring and tell them what's going on." Another member of staff told us, "I feel it's pretty open and honest, everyone is quite happy."

Staff meetings did not take place regularly. Communication of changes, training and other important information was carried out through emails and calls with the registered manager. Staff we spoke with said they would recommend the service as a place to work or receive care.

The service had not conducted any formal feedback gathering in the form of surveys or questionnaires since our last inspection. The registered manager did visit people regularly and conducted care visits where they would ask if there was anything people needed or wanted to raise. One person said, "The registered manager has been to see me, ask how I'm doing, have a look around at my hand rails and that." A relative we spoke with told us, "A couple of years ago there was a questionnaire, but the registered manager will regularly come round and chat. They will ask if everything is alright so they are asking for feedback. Also if there is anything it doesn't matter if it's over the weekend they can ring me if they want to know something urgently or if I felt it was urgent to talk about something I would feel totally comfortable."

The registered manager submitted statutory notifications appropriately. Statutory notifications are notifications of significant events such as deaths or serious injuries that registered providers are required to send to us.