Lincolns Care Limited

Lincolns Care Ltd

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**

Summary of findings

Overall summary

Lincolns Care Ltd is a domiciliary care agency. It provides personal care to people living in their own houses and flats; it provides a service to older adults and younger adults.

Not everyone using Lincolns Care Ltd receives the regulated activity; CQC 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.

This announced inspection took place on 21, 22 and 27 March 2018. This was the first inspection of this service since their CQC registration changed in December 2016. There were nine people, receiving the regulated activity of personal care at the time of this inspection.

The service had a registered manager. 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.

Staff had an understanding of the Mental Capacity Act 2005 (MCA). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Although not all peoples capacity had been formally assessed. Staff knew how to and where to report any suspicions poor care practice or harm.

People were assisted to take their medication as prescribed. However there were some inconsistencies within people's care records and risk assessments over whether people were able to manage their medication themselves or required staff assistance.

Processes were in place and followed by staff members to make sure that infection prevention and control was promoted and the risk of cross contamination was reduced as far as possible when supporting people.

Staff assisted people in a caring, patient and respectful way. People's dignity and privacy was promoted and maintained by the staff members supporting them.

People and their relatives were given the opportunity to be involved in the setting up and review of people's individual support and care plans. People were supported by staff to have enough to eat and drink.

People were assisted to access a range of external health care professionals and were supported by staff to maintain their health and well-being. Staff and external health care professionals, would, when required, support people at the end of their life, to have a comfortable and as dignified a death as possible.

People had care and support plans in place which documented their needs. These plans informed staff on

how a person would like their care and support to be given, and how it was to be given in line with external health and social care professional guidance. However, some people's care, support plans lacked detailed information for staff on how to assist people with their specific health conditions and support needs.

There were enough staff to meet people's individual care and support needs. Individual risks to people were identified and monitored by staff. Plans were put into place to encourage people to live as safe and independent a life as practicable. However, people's risk assessments sometimes lacked detailed information as guidance for staff to refer to on how to mitigate people's known risks.

Accident and incidents that occurred at the service were recorded. Learning from these incidents were communicated to staff during team meetings. This was to reduce the risk of recurrence and drive improvements forward.

There was a recruitment process in place and staff were only employed within the service after all essential checks had been suitably completed. The standard of staff members' work performance was reviewed through spot checks, supervisions and appraisals.

Not all staff had been sufficiently trained to be able to provide care which met people's individual needs effectively and safely.

Compliments about the care and support provided had been received. Records showed that there had been no documented complaints received by the service since the last inspection.

The registered manager sought feedback about the quality of the service provided from people, and their relatives. Audits were undertaken to monitor the quality of the service provided. However, shortfalls that had been identified, action to bring about the required improvement had not always been recorded to demonstrate that action had been taken.

The provider's records showed that some incidents that the provider was legally obliged to notify the CQC of had been submitted.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Actions taken as a result of any accidents and incidents were discussed at staff meetings.

There was a lack of detailed guidance for staff within people's risk assessments to help mitigate people's known risks.

There was an adequate number of staff to meet people's assessed needs and recruitment checks were in place.

Processes were in place to ensure that people's medication was managed safely. However, accurate records that recorded this support were not always kept.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs and choices were assessed and promoted. However, people's mental capacity had not been formally assessed.

Staff received supervisions, and appraisals. Staff did not always have formal practical training on how to use moving and handling equipment.

Staff worked with other organisations to deliver effective care and support.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect when being supported by staff.

People were involved in making decisions about their care and support needs.

Staff promoted and maintained people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and staff used this information to deliver personalised care that met people's needs.

Staff would work with external health professionals to support a person who was end-of-life.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in place.

Monitoring was in place to oversee the quality of the service provided. However, actions taken to make any necessary improvements were not always recorded.

People and their relatives' were encouraged to give feedback on the quality of care provided.

Lincolns Care Ltd

Detailed findings

Background to this inspection

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

The announced inspection site visit activity started on 21 March 2018 and ended on 27 March 2018. We gave the provider 48 hours' notice of the inspection. This was so that we could be sure that the registered manager and staff would be available during this inspection. The inspection was carried out by one inspector. We visited the office location on 21 and 27 March to see the registered manager and staff, to review care records and records in relation to the management of the service. We spoke with a person and relatives of people who used the service on the 22 and 27 March 2018.

The provider did not meet the minimum requirement of completing the Provider Information Return of at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made judgements in this report.

Before the inspection we looked at all the information we held about the service and the provider. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. We also asked for information from representatives of both the local authority contracts monitoring team and quality improvement team, safeguarding team; and Health watch. We sent out questionnaires to people, relatives of people who used this service and health and social care professionals to feedback on the quality of care provided prior to the inspection,. This helped us with planning this inspection.

During the inspection we spoke with one person and three relatives of people who used the service. We also spoke with the nominated individual, the registered manager; a senior support worker and two support workers.

We looked at two people's care records and records in relation to the management of the service; accident

and incident records; business continuity plan; management of staff; and the management of people's medicines. We also looked at the provider's statement of purpose; policies and procedures on training, end of life care, medication and recruitment; service user guide; surveys; meeting minutes; compliments received; staff training records; and four staff files.

Requires Improvement

Is the service safe?

Our findings

People's care and support plans were stored securely within the office and copies were stored within people's own homes. Risks to people had been identified prior to when they first started to use the service. Individual records were written for each person who used the service, with regards to their known risks. These records were in place to provide information for staff on how to assist people safely, and how to reduce the identified risks whilst still promoting peoples independence. However, we found that detailed information for staff, including a lack of guidance for staff on the maximum temperature a person's bath and shower water should be to reduce the risk of scalding. This meant that there was an increased risk of staff not having detailed information to deliver safe care and support to people. The registered manager told us that they were aware that people's risk assessments were not as detailed as they could have been and that this had been identified as an area requiring improvement.

Technology was used to support people, who required additional assistance, to receive safe care and support. For example a lifeline (alarm to be worn) that could summon support when needed in an emergency. However, staff did not always document (confirm) after each care call that they had checked to see that the person was wearing their lifeline. The registered manager told us that there was an expectation for this safety check to be documented by staff at the end of each care call. This meant that staff did not record all of the safety checks that they were asked to do as part of the care call.

People who used the service were assessed as either able to manage their prescribed medications themselves, or whether they needed assistance from staff. Some people's care records did not clearly define who was responsible for the ordering, collecting and the disposal of people's medication. We also noted some inconsistencies within people's care records and risk assessments over whether a person was able to manage their medication themselves or required staff assistance. This meant that there was an increased risk of misinterpretation of these tasks by staff.

The majority of people, and relatives' of people spoken with told us that they either managed their own or their family member's medication themselves. People and relatives' of people who required additional assistance had no concerns about how staff helped with their, their family member's, medication. Staff told us that they had received training before they could administer people's medication and that their competency to do this was checked by a more senior staff member. Records of people's medication administration were checked, as part of the services governance systems. These checks were to ensure that people's medication administration records were accurate. However, the actions taken to reduce the risk of recurrence, when any staff errors in recording (gaps in records) or administration of medication were found, were not always recorded. This meant that there was a lack of processes in place to make sure that people's medication was managed safely and recorded accurately.

A person and relatives' of people who used the service said that they, their family member, felt reassured using the service, and that the service enabled people to stay in their own homes. This was because of the support and care provided by the staff. A relative told us, "I was ill and [family member] had to go into a care home, so having this care in your own home service means that [family member] can be supported at home,

which is what we want."

Staff knew how to safeguard people from avoidable harm and poor care. Staff told us they would report any concerns in accordance with their training and that they would be confident to whistle-blow. (This is a process where staff can report any poor standards of care if they ever became aware of this). Staff described to us how they would report poor care and suspicions of harm both internally to the registered manager and to external agencies. A staff member said, "I would contact the registered manager or [local authority] safeguarding team…If I believed something was being done incorrectly, I would talk to [named registered manager] or the owner." We saw that information and guidance about how to report concerns displayed on the office notice board as a prompt for staff to refer to if needed. This showed that there were processes in place to reduce the risk of poor care practice.

A person and relatives' of people using the service confirmed to us that they, their family member, made their own decisions about their care and support needs. They said that their choices were respected and listened to by staff. One relative said, "My standards are very high, whatever I have asked for [by staff] has been done….staff do listen to requests." Records showed that people, where possible, or their relative, had signed to say they had agreed with their plans of care, support required and risk taking. This showed that people, and where this additional support was required; their relatives were aware and involved in care decisions.

A person and relatives' of people told us that they had the same staff members' supporting them at their care calls. This meant that people got to know the staff members' supporting them and staff got to know them and how they liked to be assisted. They also told us that staff arrived on time (within the plus or minus 15 minute tolerance) for their, their family member's, care calls. A person said, "[Staff] are always on time and do what I want them to do." A relative told us, "[Staff] have been on time, they even came when the snow was very bad down here…staff are on time so my [family member] is not left waiting and worrying. This is really important to us." Another relative said, "Consistent staff gives [family member] confidence… Staff engage [with family member] and know the routine." The registered manager said that although they currently had enough staff to cover the care calls, they did struggle to recruit new staff members. They told us that they were looking a different ways to encourage new staff to join. This meant that during this inspection, there was sufficient numbers of staff to look after people with a continuity of care and support.

Checks were carried out on new staff members to confirm that they were appropriate to work with people and were of good character. Staff told us that these checks were in place before they could start work at the service. This showed us that there was a process in place to make sure that staff were deemed satisfactory and suitable to work with the people they supported.

Staff were aware of their role in preventing the spread of infection and cross contamination, when supporting a person with their personal care and when helping people with their food preparation. Staff told us that they had enough cleaning equipment and personal protective equipment (PPE) available to use. Staff received training on food hygiene and how to prevent or manage any potential infections. This showed us that procedures were in place to help reduce the risk of infection and cross contamination.

Accident and incidents that occurred at the service were discussed during team meetings. A staff member confirmed to us that after the first CQC inspection day, the registered manager had spoken to staff about the importance of accurately recording people's prescribed medication. A staff member said, "Lessons learnt re audits or incidents are referred to at staff meetings." This showed that lessons and any improvements required were communicated to staff to reduce the risk of recurrence.

Requires Improvement

Is the service effective?

Our findings

Staff were required to complete mandatory training, in line with the providers training policy to ensure that they had the right skills to provide the individual care and support people needed. Training completed by staff included, equality and diversity; food hygiene and safety; moving and handling; safeguarding; safe handling of medicines; infection control and fire safety. Training was also undertaken on dementia and cognitive issues and basic life support. Training was delivered via e-learning (computer training) and we saw that one staff member's refresher training was overdue. The registered manager told us that any staff that did not complete their refresher training in a timely manner would be stopped from attending care calls until the refresher training had been completed.

The registered manager also made us aware that two new staff members had completed moving and handling training via e-learning. However, they said that these staff had not been given practical training, from a certified training company, on the moving and handling equipment they would be expected to use. The registered manager told us that the new staff members had been, 'shown' how to use equipment whilst supporting a more experienced staff member during care calls. However, a lack of practical formal training on how to use specialist equipment meant that there was an increased risk that people would be at risk of ineffective, unsafe moving and handling procedures. This showed us that were not robust and correct processes in place to make sure that staff were given training to help them provide effective care and support.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Staff were able to demonstrate an adequate understanding of why it was important to encourage people to make their own choices. A person and relatives' of people told us that staff listened to and respected their choices. Staff supported people with their decision making using visual or verbal prompts. One staff member said, "You give choices, visual prompts re ready meals and the person can then make a choice." However, the registered manager told us that some people using the service may lack mental capacity to make day-to-day decisions and be unable to understand and retain information. We found that although there were prompts for staff within people's care records to deliver care in people's 'best interests;' there was a lack of documented evidence to show that people's mental capacity had been assessed to determine whether they could make day-to-day decisions for themselves. As such, there had been no requests for social workers to make applications with the appropriate authority regarding people who may lack the mental capacity to retain information and consent to their care and support. This showed that there was an increased risk that people would have their freedom restricted in an unlawful manner.

External health and social care professionals, such as social workers, district nurses and an occupational therapist, were also involved in people's well-being. The registered manager told us that they looked at the CQC website for guidance and legislation updates and received email alerts re updated guidance from the external organisation that had assisted them in producing their policies and procedures.

The registered manager talked us through examples of how they ensured that there had been no discrimination for people and the staff they employed when supporting people with their care and support needs. This included an agreement with a person's social worker that staff supported the person to attend religious services. One person also told us that they had been supported by care staff initially, who due to their religious beliefs were uncomfortable at preparing and cooking certain foods. After speaking to the registered manager, this was resolved to both the person and the staff members' satisfaction. A staff member confirmed to us, "My religion is respected and the service users' religion, culture and wishes are also respected." This showed us that the registered manager and staff worked in conjunction with the Equality Act and with external health and social care professionals to try to make sure people's needs were met in line with up-to-date guidance and good practice.

People were assessed for and used equipment to promote their mobility. Support given by staff, a relative told us, gave their family member reassurance when they were using this equipment. They said, "[Staff say] are you ready [named person], I am going to hoist you now. [Staff] talk [named person] through it step by step."

Staff told us that they felt supported and listened to by the registered manager. This support was provided through spot checks, supervisions and appraisals. Staff said that these were carried out by the registered manager and that these were a 'two-way' (joint) conversation. A staff member told us, "I have monthly supervisions and an appraisal once a year. Spot checks are once a month or sooner if something has not gone right." When new to the service staff had an induction period, where they completed the 'care certificate.' This is a nationally recognised health and social care induction training programme. This induction included training and shadowing a more experienced member of staff. This was in place until staff were deemed competent and confident by the registered manager to provide support and care to people.

People could choose to prepare and make their own meals with some assistance from a staff member. The majority of people and their relatives' spoken with told us that they, their relative, prepared their meals and drinks. For people supported by staff, they told us that they had no concerns with this assistance. We saw that people's individual food and drink likes and dislikes were clearly documented as reminders for staff.

The service worked and communicated with external organisations to make sure that staff could meet people's needs. For example, we saw recorded evidence of the registered manager communicating with the person's social worker to make sure that the person's needs were met as far as practicable.

A person and people's relatives' told us that they, their family member were able to attend external health care appointments independently or with support from their relative.

Good

Is the service caring?

Our findings

A person and relatives' of people had very positive opinions about the care and support provided by staff. They told us that although staff helped them with their care and support needs, staff members always continued to encourage people and uphold their independence. One person said, "[Staff] encourage me to do as much as possible [myself]...They help wash my back and hair but [staff] encourage me to do things I can do for myself." A relative told us, "[Staff] are great, they talk to [family member] and get them to do physio exercises and [family member's] progressing quite well." A second relative said, "[The] care that is offered is excellent." Records gave adequate information for staff on what people were able to do for themselves and when staff were to offer people support. This meant that staff had knowledge on how to promote, and maintain people's independence.

A person and relatives' of people told us how patient, kind and caring staff were to them, or their family member. One relative said, "Staff are kind and respectful, a nice network of care [staff]…Staff always run everything through me, I like to be very much involved on every moment of the day." Another relative told us, "[The service] is the best we have ever had. When staff arrive they are polite and respectful, they are happy and smiling…I think they are the best company we have used."

The majority of people and their relatives' told us they were encouraged to express their views, were listened to and were involved in decisions about their care and support where appropriate. A person said, "I feel involved in decisions about my care, staff listen and respect my choices…I was involved in the setting up of [my] care record and my family were involved and can read the file." A relative told us, "I was involved in the setting up of [family member's] care record and reviews [of this record] are undertaken…communication is very good." However, another relative said that they were not aware or involved in the setting up of their family members care record. This they told us did not cause them any concerns.

Information on advocates was available to people on request. Advocates are people who are independent of the service and support people to make and communicate their views and wishes.

Staff had knowledge of and respected the people they were providing care and support for. They were able to show us that they knew about people's backgrounds, and any preferences they had. Wherever possible, people were supported by staff that understood, respected and valued their religious or cultural beliefs. People's dignity was promoted and maintained by staff. A person told us that when being supported with personal care, "[Staff] pull the curtains and blinds a bit…[family member] does not want me to be supported by male [staff] and they have never tried to send one." This showed us that staff respected and promoted people's wishes and dignity.

Good

Is the service responsive?

Our findings

Care and support plans and risk assessments recorded people's daily living needs, and care and support requirements at each care call. These had been developed in conjunction with the person, their relatives, legal representative and advocates prior to them using the service. These records were in place to give information to staff on how they could meet the person's individual care and support needs. Reviews of these records were then carried out to make sure that these were up-to-date and reflected people's current assessed requirements. The registered manager told us that they had already identified that people's care records needed some improvements to ensure they fully reflected people's requirements.

People, where needed, were supported by staff to maintain their links with the local community, to attend religious services, or to go shopping. This showed us that people were supported to maintain their links with the wider community.

The service received compliments from people and relatives' of people who used the service. They used to these to help identify and communicate to staff what had worked well.

The registered manager told us that they had not received any complaints since the last inspection. Records showed that no complaints had been documented. A person and relatives' of people who used the service told us that communication was good with staff at the service. One person told us, "If I had a concern I would ring the [service's] office, I'm confident to do so but have not needed to." A relative said, "Suggestions are listened to, I have rung the office a couple of times, I have the [telephone] number." This demonstrated to us that people felt confident to raise a concern and were confident that it would be taken seriously.

The registered manager told us staff were not trained in end-of-life care and that people's end-of-life wishes were not always documented. However, the providers training policy did list end-of-life training as a mandatory requirement. The registered manager told us that they would source this training and would then make this training available to staff members.

The registered manager confirmed to us that to support people approaching the end of their life they would work with the person and their family to make sure that they met their wishes, including their preferred place of death. They also told us that they would work with external health care professionals, when it became clear that people's health condition had changed or deteriorated. This was to enable staff to support people to have the most comfortable, dignified, and pain-free a death as possible. There was no-one receiving end of life care at the time of this inspection.

Care records did document people's wish to be resuscitated, however the records did not always document people's end of life wishes, including any end-of-life cultural and religious wishes; funeral arrangements; and preferences. This increased the risk that people's end-of-life wishes may not be met.

Requires Improvement

Is the service well-led?

Our findings

The provider did not meet the minimum requirement of completing the Provider Information Return at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

The registered manager checked the quality of the service provided so that people would be confident that their needs would be met. However, during audits of the quality of service provided by staff, not all shortfalls had been identified. For example, inaccurate recording of people medication administration records had not been noted until pointed out by the inspector. We noted that areas of improvement had been found during the audit of a person's care record; however any actions taken to address this had not been documented. This meant that there was an increased risk that any errors or issues had not been followed up or addressed to improve the service provided.

A registered manager was in place, who was supported by, senior support staff, and support staff. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Records showed notifications had been received from the registered manager that they were legally obliged to notify us of.

Staff told us that there was an expectation, from the registered manager, for them to deliver good quality care and support. One staff member said, "The [service's] values were to give very good care to people."

Staff told us that the registered manager was approachable and listened to their suggestions and concerns and that they felt supported. A relative confirmed to us that, "Communication is very good." A staff member told us, "On-call [telephone line] it is always answered."

Evidence of learning as a result of audits undertaken, accidents and incidents was discussed at staff meetings, to learn, improve and sustain the quality of the service provided. Examples included a reminder of staff about the importance of documenting peoples' medication administration accurately.

People and the majority of their relatives' told us that they were asked to give feedback on the quality of the service provided. This feedback was requested during telephone interviews and questionnaires. Records showed that responses were in the main positive. Any areas for improvement were noted and where possible they were being acted upon. For example, staff were reminded to continue to promote a person's independence.

The registered manager told us and emails showed how they worked in partnership with and shared information with key organisations. This included communicating with people's social workers about

people's individual care and support needs. This showed us that the registered manager shared and sought appropriate information with other relevant agencies where appropriate to benefit the people using the service.