Care Quality Commission

# Harley Street Care Limited

# Harley Street Care

**Inspection report**

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## Ratings

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

## Overall summary

The inspection took place on 10 and 17 August 2015 and was announced. We gave 72 hours' notice of the inspection to make sure the staff we needed to speak with were available at the location.

Harley Street Care is a domiciliary care service which provides personal care services to people living in their own homes. At the time of this inspection there were 12 people receiving a service.

The service did not have 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.

The provider carried out a range of checks to ensure that suitable staff were recruited; however, some references were not verified in order to make sure they were authentic. This meant people could have been placed at risk from recruitment that was not sufficiently robust.

People's representatives told us that people felt safe with the staff. Systems were in place to make sure that people

# Summary of findings

were protected from the risk of abuse. Staff were aware of the provider's safeguarding policy and procedure, and understood how to identify and report any safeguarding concerns.

Risk assessments had been carried out and staff received guidance about how to minimise the risk of harm occurring.

There were sufficient staff employed and people's representatives told us the provider ensured people received care from regular care staff who clearly understood their needs and preferences.

Medicines were safely administered by staff with training, and support from the care manager.

People's representatives told us staff shared information about a person's care, with their consent. People's rights were upheld as required by the Mental Capacity Act (MCA) 2005. This law provides a framework to protect people who do not have capacity to give their consent or make certain decisions for themselves. Staff had received guidance about MCA during their induction.

Staff supported people with their nutritional needs and the provider liaised with health care professionals when required, in order to ensure people's needs were properly met.

Staff were described as being kind, gentle and patient. They demonstrated an understanding of how to support people in a respectful way that promoted people's dignity and privacy.

People's representatives told us that the provider consulted people about their preferences and wishes as part of the care planning and reviewing process.

Information was given to people about how to make a complaint.

The provider had systems in place to monitor the quality of the service and seek people's views. This included regular visits to people, telephone calls and auditing of people's daily records.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

**Requires improvement**

The service was not always safe.

The provider did not consistently ensure that staff references were verified, in order to ensure their authenticity.

There were sufficient staff employed to safely meet people's needs.

Staff had received safeguarding training and understood the actions they should take if they had any concerns.

Risk assessments were carried out and plans were in place to minimise any identified risks.

Staff were trained to support people with their medicines and systems were in place to check that medicines were accurately managed.

**Is the service effective?**

**Good**

The service was effective.

Staff were provided with relevant training and support to meet people's needs.

The provider had taken actions to meet its' responsibilities in regard to the Mental Capacity Act (MCA) 2005.

Care plans contained guidance about how to meet people's nutritional needs, which included information about individual preferences and mealtime routines.

The provider liaised with people, and their relatives and representatives where applicable, to ensure that people's health care needs were identified and documented in their care plans.

**Is the service caring?**

**Good**

The service was caring.

People told us that the care staff were kind and caring, and the office staff were polite and helpful.

Staff demonstrated an understanding of how to meet people's needs in a way that maintained their privacy, dignity and confidentiality.

**Is the service responsive?**

**Good**

The service was responsive.

Care plans were frequently reviewed and took into account the views of people using the service and their relatives.

People were informed about how to raise any concerns and complaints.

# Summary of findings

**Is the service well-led?**

Good

The service was well-led.

People using the service told us the care manager listened to them and was contactable.

Regular visits and telephone monitoring calls were conducted by the management team to ensure people were pleased with the quality of care they received.

# Harley Street 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.

The inspection took place on 10 and 17 August 2015 and was announced. We told the provider three days before our visit that we would be coming. This was because senior staff are sometimes away from the office location visiting people who use the service and supporting care staff; we needed to be sure that someone would be available. The inspection team comprised two inspectors on the first day and one inspector on the second day.

Before the inspection visit we read the information we held about the service. This included the previous inspection report, which showed that the service met the regulations we inspected on 27 September 2013. We also checked statutory notifications sent to us by the provider about significant incidents and events that had occurred at the service, which the provider is required to send to us by law.

As part of the inspection we spoke with the representative of one person who used the service and the representatives of two other people sent us written comments. During the inspection we met the care manager, the care co-ordinator, the managing director and a director. We spoke by telephone with two care staff. We checked records which included four care plans, five staff recruitment and training files, the complaints log, the safeguarding vulnerable people policy and procedure, and the whistleblowing policy.

We contacted community health and social care professionals with knowledge about the service and received comments from one professional.

Requires improvement

# Is the service safe?

## Our findings

The provider's recruitment policy stated that all references needed to be verified in order to ascertain their authenticity, which meant that referees should be telephoned to check they wrote the reference and if necessary, their job title and authority to give references within their organisation should be confirmed. However, we saw that this practice was not consistently adhered to. This meant people could have been placed at risk of receiving care from staff not suitable to work for the provider. The recruitment files we looked at showed a minimum of two relevant references were obtained and other checks were carried out. These included proof of identity and address, evidence of staff's entitlement to work in the UK and criminal record checks. Prospective employees were asked to explain about any gaps in their employment, education and training history, and this was recorded.

People's representatives told us there were sufficient staff employed in order to provide people with a reliable and consistent service. One person's representative said, "We have been able to get to know our regular carer and she is like a friend to us. They find very suitable stand-ins for when our carer is on holiday." The care staff told us they were assigned to provide care for one or two people and they liked developing good relationships with people and their family members and friends.

People's representatives said people felt safe with care staff. One representative told us, "The staff are all very suitable and we have confidence in them." Another representative said, "Staff have excellent integrity, we have no concerns about the safety of [family member]."

The training records showed that staff had received safeguarding training. The care staff we spoke with provided competent explanations about the different types of abuse that people could be at risk of, and they described the signs that might indicate a person was being abused or was at risk of abuse. Staff were aware of their role in reporting abuse in line with the provider's policy and local authority protocols. One member of the care staff said, "I would immediately speak with the care manager if I had concerns and they would keep me informed about what actions have been taken."

Assessments were carried out to assess any risks to people using the service and to the staff providing their care and support. There were risk management plans in place to provide guidance for staff about how care and support should be delivered to reduce the identified risks, and keep people safe and as independent as possible. Environmental risk assessments had been developed in order to minimise hazards to people and staff when working in people's homes.

Records showed that staff had received medicines training and staff confirmed they were familiar with the provider's medicines policy and procedure. The medicine administration record (MAR) charts we looked at had clear instructions and there was guidance about how to support people with their medicine needs in their care plans. Completed MAR charts were brought back to the office and checked by the care manager, in order to check for any occasions that medicines were not signed for. A member of the care staff told us the care manager also checked MAR charts when visiting people, which meant staff were vigilant about ensuring they maintained accurate record keeping.

People's representatives told us they knew how to contact the provider during out of office hours and had never experienced any difficulties in reaching a member of the management team whenever required. The director and the care manager said they took it in turns to provide the on-call service. Care staff told us they felt well supported by the provider at all times and had rung for advice during evening, night-time and weekend shifts. This was confirmed by daily records completed by care staff, which showed that discussions about people's needs and wellbeing took place between care staff and the on-call manager during out of office hours.

Good

# Is the service effective?

## Our findings

People's representatives told us they were happy with how the service supported people. Comments included, "It is an excellent service and we are very impressed" and "I am very pleased and would recommend." People's representatives told us they felt consulted by the management team and care staff, and were invited to contribute to care planning and review meetings in accordance with the wishes of their relative or friend.

People were supported by staff who had the necessary knowledge and skills to meet their needs. The training records showed that newly appointed staff received induction training and were introduced to people before they provided care and support. Care staff told us they initially received training from the care manager about a person's needs and preferences, which included an opportunity to read the care plan and ask questions. This training session was followed by an opportunity to meet a person and shadow an experienced member of staff for a couple of shifts. One member of the care staff told us, "[Care manager] made sure I understood how to look after [person using the service] and I was observed providing care before I could work independently."

The training records showed that staff received appropriate training to meet the needs of people using the service, which included infection control, person centred care, food hygiene, health and safety, and moving and positioning. Staff had received an introduction to dementia training. The director told us they had developed links with a dementia training organisation and there were plans in place for staff to have additional training relating to dementia and the care needs of older people.

Staff told us they attended one-to-one supervision meetings with the care manager or the care co-ordinator every three months. We looked at a sample of supervision records which showed that these meetings provided an opportunity for staff to discuss the needs of people they supported, discuss their own performance, and identify training and development needs. Staff also received an annual appraisal. We noted that the provider used the supervision template to record appraisals, which potentially restricted the scope of topics for review. We discussed this with the care manager and they developed a new appraisal form during the inspection.

People's representatives told us staff sought their relative or friend's consent before providing care and support, and we saw that some people had signed their own care plans. Staff understood the principles of the Mental Capacity Act (MCA) 2005 and had read the provider's policy. The MCA is legislation that protects people who lack mental capacity to consent to certain decisions about their care and support. The care manager was aware of the need to refer people to the local authority for assessment under the MCA if they appeared to lack capacity and a family member or friend did not have a Lasting Power of Attorney for health and welfare. The care manager showed us examples of work they had carried out in regards to supporting people when potential issues regarding mental capacity had been identified. This showed the provider appropriately responded to their responsibilities.

Care plans showed people's nutritional and hydration needs were identified and staff were provided with detailed guidance about how to meet these needs, taking into account people's own preferences and routines. Care staff told us their responsibilities varied, but included food preparation, prompting and supporting people with eating and monitoring their daily intake. Records kept by the care manager showed that the provider liaised with people's representatives and relevant healthcare professionals if staff identified concerns about people's eating and drinking.

People's representatives told us the provider informed them of any health care concerns staff had observed. Most people using the service were primarily supported with their health care needs by a family member or friend. We looked at a care plan for a person who required more intensive staff support to meet their healthcare needs, which documented how the care manager contacted the person's GP and district nurses when staff reported concerns. Records showed the care manager was thorough and rigorously followed up any requests for visits by healthcare practitioners, which demonstrated that the provider had systems in place for supporting people to access health care. The care plans contained the contact details of people's GPs and other health care practitioners.

Good

# Is the service caring?

## Our findings

People's representatives told us staff were kind and caring. Comments included, "The staff are patient and enjoy their roles", "They have a very calm manner" and "Our care staff are gentle and lovely."

People's own wishes about how they wanted to receive their care and support were recorded in their care plans, which were extremely detailed and person centred. Care plans included information about people's social interests, life history, family and friends support network, and cultural and religious needs. This provided staff with the appropriate information to provide individualised care and support. For example, one care plan described how a person liked to spend some of their time at home but it was also important to attend events and stay with friends and family members. Care plans also included information about how people wished to retain their independence and which daily living tasks they chose to carry out on their own or with minimal assistance.

Staff were familiar with people's care plans and were able to inform us about people's needs and preferences. They told us they had received guidance about how to treat people in a respectful way, for example, ensuring people were supported with their personal care in a manner that promoted their dignity and comfort. One staff member told us they made sure that doors were closed and curtains pulled when they supported a person with their personal care. One care plan explained the support a person required with attending to their appearance before they received visitors.

People's representative's told us staff were punctual and reliable. Staff said they would call the office if they were held up in traffic and the message would be relayed to people, with an apology. A community professional commented upon the consistent good conduct and pleasant approach shown by care staff.

The provider had a policy in regards to how staff should manage confidential information and when such information could be disclosed, for example, information could be shared with relevant health and social care professionals on a need to know basis. Staff demonstrated their understanding of this policy.

People were provided with a copy of the complaints policy and procedure. The care manager told us that most people who used the service were self-funding and their preference was to seek advice from family members, friends or their solicitor rather than use advocacy services.

Good

# Is the service responsive?

## Our findings

People's representatives told us staff were knowledgeable about the needs and preferences of their relative or friend. The care manager told us they always carried out an assessment of a person's needs, which took into account their likes and dislikes, before developing a plan of care to outline how to meet these needs. The care plans for people who were funded by a clinical commissioning group (CCG) or a local authority incorporated information from the assessments conducted by health and social care professionals. Other care plans showed the care manager sought health and social care information from people and their representatives, which showed the provider's commitment to planning and delivering care that responded to people's changing needs.

The assessments and care plans were reviewed every three to six months depending upon people's needs and circumstances. Care plans gave detailed and specific information about how to meet people's needs. For example, one person was prone to developing pressure sores and the care plans for nutrition, mobility and tissue viability were updated whenever there was any significant change, which could be weekly or fortnightly. The care manager told us they visited some people every couple of weeks to monitor and review their care, which was demonstrated in the risk assessments, care plans and daily record sheets.

The daily records were also detailed and provided clear information about the care and support given by care staff, which enabled other care staff to take over a person's care and access full information about the person's day to day needs. These records were checked by the care manager to check for any significant changes in people's needs, which might indicate the need for their care to be reviewed.

People's representatives told us staff got on well with the people they supported. The care manager told us they attempted to match people with staff, in terms of shared interests and experiences. For example one person using the service had frequently travelled and lived abroad and their care staff had similar experiences.

People's representatives confirmed they knew how to make a complaint and told us they had been provided with a brochure containing complaints guidance. None of the representatives we spoke with had ever needed to make a complaint and they expressed their belief that any complaints would be professionally managed. The provider had not received any complaints since the previous inspection visit and showed us written compliments from people using the service.

Good

# Is the service well-led?

## Our findings

People's representatives told us they thought the service was well managed. Comments included, "I have confidence in this service", "We think it's very good" and "I am particularly impressed with the care manager."

The care manager told us they received managerial support from the director and the care co-ordinator was supervised and supported by the care manager. The director told us the management team could access support from a clinician, who provided guidance about meeting people's health care needs. We saw that the provider had sought advice about how to manage the needs of a person with behaviour that challenges.

At the time of this inspection there was no registered manager in post. The director had informed the Care Quality Commission and was in the process of recruiting a new manager. Candidates had been shortlisted and the director acknowledged the need to ensure the position was filled as promptly as possible.

The provider had different methods of monitoring the quality of the service. The care manager and the care co-ordinator regularly visited people at home to find out their views and experiences of using the service and also carried out telephone calls monitoring. They both did shifts at people's homes from time to time. The care manager told us they sometimes provided the care and support for a person with complex needs who required two care staff, which allowed them to monitor the performance of care staff. Care staff told us that although the care manager and care co-ordinator sometimes gave notice of their intention to visit a person at home, there were also 'spot checks' which they did not get prior notice of.

Staff were aware of their responsibility to report any accidents or incidents. People's daily records were scrutinised by the care manager to check for any issues that might not have been reported. Checks were also made to ensure that care was being delivered in accordance to the care plan and people were written about in a detailed and respectful way.

The provider had a whistleblowing policy and procedure, and staff were able to tell us how they would use it to report any concerns about the provider and the service.