L S Care Limited

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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?	Good

Summary of findings

Overall summary

This inspection took place on 6, 7 and 8 February 2017. The inspection was announced. We last inspected the service in September 2015 and asked the provider to take action to make improvements to medicines management and mental capacity. An action plan was submitted by the provider and we found the action had been completed.

L S Care Limited provides nursing and personal care for people living in their own homes, some of whom have complex health needs. L S Care Limited is also registered to provide care for children under the age of 18. At the time of the inspection they were supporting 26 people living across Northumberland, Newcastle, South Tyneside, North Tyneside and Gateshead. Some people received care and support 24 hours a day whilst other people had visiting support.

There were two registered managers 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.

People and their relatives said they felt safe receiving care from staff. They said they felt staff were caring and treated them with dignity and respect. People also thought staff were well trained and had the knowledge they needed to care for them appropriately.

Medicines were managed safely and new procedures and training had been developed since the last inspection.

Staff had attended mandatory training in areas such as safeguarding, moving and handling and medicines management. Staff also attended training relevant to any specific needs of the people they were supporting, such as the use of ventilators, suction machines and feeding tubes. Staff also attended training on specific diagnoses such as motor neurone disease.

Staff told us they felt well supported by the management team. They said they had regular supervisions and an annual appraisal. They also said they could access out of hours support and advice when needed.

Complaints, safeguarding concerns, accidents and incidents were documented, investigated and discussed in regular quality meetings.

Capacity was recorded within care records which made it very clear that people had been involved in developing their care plans and risk assessments and were able to direct their own care and support. If there was a concern that someone may lack capacity, appropriate professionals were involved and the provider

completed an internal assessment of capacity. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Robust recruitment practices were in place which supported the recruitment of appropriate staff. Practice included confirming references and seeking Disclosure and Barring Service Checks which were renewed every three years.

Care records and risk assessments were detailed and personalised. People's likes and dislikes were documented, including their preferred routines and how they wanted to be supported. The clinical and training managers visited people and reviewed their care packages on a monthly basis. The views of people, relatives and staff were all considered and everyone worked together to achieve positive outcomes with people.

Staff, people and relatives told us they thought L S Care Limited was well-led. Quarterly audits were completed to ensure care records met the required standard, were up to date and detailed.

Staff felt they were well supported and could seek the advice and guidance of the management team as and when needed.

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.

Medicines were managed safely.

People had a core team of staff who knew their needs well and were appropriately skilled and competent to support them.

Risks were assessed and well managed.

Staff understood reporting procedures for safeguarding adults and children.

Is the service effective?

Good

The service was effective.

Staff completed training in mandatory areas and those specific to the needs of people they were supporting.

The principles of the Mental Capacity Act (2005) were followed and care plans were very clear that people had capacity to made decisions.

People were supported with meeting their nutritional needs and had access to external health care professionals and internal clinical managers.

Is the service caring?

Good

The service was caring.

People and their relatives, where appropriate, were involved in care planning and reviews. Parents of the children supported by the service were consulted on care plans and any proposed changes to care plans were discussed with people and families in advance.

People and their relatives were very positive about the care they received. People said they were treated with dignity and respect and the support they received was invaluable.

Is the service responsive?

Good

The service was responsive.

Care records were personalised and included detailed routines for staff to follow. There was also information on people's individual preferences and the areas where people did not need support which encouraged people to remain independent.

Complaints were recorded and investigated. Apologies were readily offered where relevant and appropriate.

Is the service well-led?

Good

The service was well-led.

The management team included directors, registered managers and clinical and training managers who were supportive of people and staff.

Regular audits were completed and the clinical managers made weekly visits to see people.

Staff said they felt well supported and listened to by the management team.

L S Care Limited

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 inspection took place on 6, 7 and 8 February 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be at the office to support the inspection.

The inspection team was made up on one adult social care inspector and one Expert by Experience. 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 reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We also contacted the local authority commissioning team, the clinical commissioning group (CCG) and the safeguarding adult's team.

During the inspection we spoke with six people using the service and two relatives. We also spoke with the registered manager, a second registered manager who was also a director, another director who was also the nominated individual, a senior clinical and training manager, a clinical and training manager, three care staff and one senior care worker.

We reviewed five people's care records and seven staff files including recruitment, supervision and training information. We reviewed four people's medicine records, as well as records relating to the management of the service.

Good

Is the service safe?

Our findings

During our last inspection in September 2015 we found the provider did not ensure the proper and safe management of medicines. They did not ensure prescribed medicines were available at all times. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

During this inspection we found improvements had been made to ensure regulations were met, and people's medicines were managed safely.

We spoke with people about the management of their medicines. One person said, "I don't require any help with medicines as I self-medicate." Another person told us, "I'm happy, I get my meds on time and everything is all in good order – it's all excellent." One care worker said, "I'm fully trained in medication and have recently completed a safe handling of medication certificate."

Medicine care plans were in place and included information on how people liked to be supported with their medicines. Pain management plans also included information on whether people experienced pain routinely, where the pain would most likely be and what it was related to, if known. There was also information on how this would be communicated, and the action staff should take to support the person. For example, pain relief, repositioning the person to a more comfortable position and seeking advice.

Medicine administration records (MARs) were in place and a coding system was used to record any refused or not required medicines with notes recorded to explain why. If people had their medicines administered through a feeding tube this was recorded and included the flush that was required pre and post medicine administration.

The senior clinical and training manager said, "A medicine test has been introduced on an annual basis following the last inspection which includes dispensing instructions, checks on medicine stock, completion of MARs, key codes, medicine errors, and when to contact the office." They added, "They are marked and there is a pass rate which most people are meeting."

We spoke with people and their relatives about the care they received. Everyone we spoke with confirmed that they or their family member felt safe and the care provided and equipment used was also safe. One person said, "They are all very good people and I feel very safe and comfortable when they're here." A relative told us, "The support from L S Care is invaluable. It helps me as much as it helps my [family member] and everything is spot on. My [family member] is very vulnerable but I have no concerns about the support that's provided or the equipment they use."

Care staff explained they keep people safe by following care plans, policies and procedures and attending training. One care worker said, "I keep people safe by working to care plans and risk assessments. I look after the welfare of the service user and I attend all training. I am aware of safeguarding and will whistle blow if I think the service user is being abused or harmed in any way." They went on to say, "Safeguarding means to

protect people from harm, abuse and neglect and to protect their human rights. Safeguarding enables you to report any form of neglect or abuse." Another care worker said, "Safeguarding is protecting vulnerable adults and children from abuse or neglect. IT means making sure people are supported to get good access to health care and stay well." A senior care worker said, "If I had any concerns I would raise a safeguarding myself. The care plan is about keeping people 100% safe but I would raise things with professionals and the manager. I'd also pull the person to one side but I would definitely raise it."

Both child and adult safeguarding policies were in place and described the actions staff should take to report and record any concerns. Contact details for all the local authority safeguarding teams L S Care Limited currently work in were available.

Risk assessments were in place for the environment as well as people's specific needs such as manual handling, pressure damage, nutritional risks, epilepsy, choking and the use of specific equipment. Risk assessments for the use of ceiling hoists included contingency plans in the case of power failure so staff had specific instructions to follow in an emergency situation. Other risk assessments included control measures to minimise the risk and action to take in the event of any concerns.

Risk assessments were specific to each person and included information on consent and the involvement of other professionals, such as the vent team or dieticians. Documents were signed by the person or by their representative. For children documents were signed by their parents and there was clear evidence of inclusion.

Emergency liaison forms were in the front of care records. These included details of who to contact in an emergency, a brief summary of the person's medical history, current care package and medicines.

Accidents and incidents were recorded and discussed in regular quality meetings. This included any medicine errors. Action had been taken, with people's consent. For example, to change pharmacy due to errors in the receipt of medicines which had been identified by care staff.

Everyone we spoke with told us care was provided by a regular group of care staff. People and their relatives also said they received rotas detailing who would be visiting them and any new care staff were introduced to them. One person said, "I have a regular group of carers but it there's a change because of sickness or whatever I get an update to the rota from the office."

One care worker said, "Yes, there's enough (staff). I work with one or two staff to each service user." They went on to explain that they had never supported someone who they did not know. They said, "I am introduced to the service user and get an opportunity to read their care plan. On more complex packages I have been trained and allowed to shadow and been assessed beforehand." A second care worker also said there was enough staff, they said, "Yes, although at times due to sickness it must be a struggle for management to juggle everyone around. I've always been introduced to people (I support)."

Recruitment processes included an application form and interview. A minimum of two references and a disclosure and barring service (DBS) check were in place before staff commenced employment. DBS checks help employers make safe decisions as they provide information about an applicant's criminal record and whether they have been barred from working with vulnerable adults and children. DBS checks were renewed every three years.

Good

Is the service effective?

Our findings

During our last inspection in September 2015 we found the provider was not acting in accordance with the Mental Capacity Act (2005) Code of Practice. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent.

During this inspection we found improvements had been made to ensure regulations were met, and the Code of Practice was being followed.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. If a person is receiving care in a community based environment, arranged by the local authority, the Court of Protection must authorise any deprivation of liberty. This is the only route available. No one supported by L S Care Limited had been assessed as lacking mental capacity and therefore no applications had been made to the Court of Protection.

Care staff were able to explain what mental capacity meant. One staff member said, "Mental capacity means being able to make their own decisions and being able to understand their decisions and its consequences. I would support this by encouraging service users to make their own decisions and also being aware of any dangers or harm that could occur because of the decision. I would report any queries or doubt to my manager and seek advice." One person said, "They (staff) seek consent before any support and they respond to my needs." One care worker was able to describe the principles of MCA. They said, "It provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves." They added, "Mental capacity means being able to make your own decisions. Someone lacking capacity, because of an illness or disability such as a mental health problem, dementia or a learning disability, cannot do one or more of the following four things: understand information given to them about a particular decision. Retain that information long enough to be able to make the decision. Weigh up the information available to make the decision. Communicate their decision."

Where an external professional had queried one person's capacity, LS Care had responded by informing the social worker and safeguarding team and completing a mental capacity assessment. The assessment had concluded the person did have capacity to make specific decisions in relation to their nutritional needs.

We spoke with people about whether they thought staff were well trained and knowledgeable. One person told us, "If there's been a new carer they come and shadow the existing ones for a couple of days so they get to know me and what's needed." A second person said, "The problem is sometimes the carers don't deploy all of their skills for maybe four months because my medical needs change and they 'forget' what to do.

When this happens I just contact the office and they arrange for [clinical trainer] to do some refresher training." Another person said, "I am more or less confined to bed but I would say the carers are all skilled." One relative explained that they had been concerned due to a limited number of staff having the specialised training needed to support their family member but they said it was now happening.

The senior clinical and training manager explained staff attended a general induction to L S Care which included mandatory training such as safeguarding, moving and handling and medicines. Staff then completed a specific induction in relation to the person they would be supporting. This included shadowing, specific training and competency assessments. Competency files were in place for each person who had complex needs together with a list of staff trained to support them and evidence of training and competency assessments. Staff had completed specific training such as epilepsy, emergency medicines, tracheostomy care, suction training, stroke awareness and motor neurone awareness. Staff who were new to working in social care also completed the Care Certificate.

One care worker explained that if people needed support with the use of specialist equipment staff attended training. They said, "I am competent in using special equipment, I am always trained and assessed before using it." They added that they felt well supported by the provider. They said, "I can talk to a manager or senior member of staff at any time and have regular supervisions and appraisals." A senior care worker said, "We get a full induction and training, I felt confident, we have specialist training on vents or PEG feeds, I had some physio training as well and shadowed support with the client."

As well as competency files, training records were maintained for annual refresher training which included medicines, safeguarding, end of life care, mental capacity and moving and handling. Staff training was up to date, and there was a regular roll out of annual training so staff could attend refreshers as needed.

Some of the people supported had complex health needs, including specific needs around nutrition and feeding. People told us they chose what they wanted to eat and staff provided it along with a drink or drinks of their choosing. One person said, "I get my meals on time." Some people needed support with percutaneous endoscopic gastrostomy (PEG) which are used for people of all ages, including children and babies, who are unable to swallow and need artificial nutrition. PEG tubes are also used for the administration of medicines for some people.

Staff working with people who used a PEG had been trained to meet the person's specific needs and detailed care plans and risk assessments were in place. Information was included on the reason for the person needing to use a PEG, how it should be cleaned and the person's feeding and medicine routine. We saw one person's care plan had not been updated following a change in their routine. The clinical and training manager said, "The information is there and the care records are due for review soon so it will be updated then." The registered manager accessed the care file from the person's home and we saw that this had been updated in line with the changes so staff had access to most current information.

Care records included guidance and advice from external professionals such as the vent team, speech and language therapy, dieticians, district nurses, occupational therapists and physiotherapists. The two clinical and training managers were registered nurses and worked closely with specialist teams to ensure they had the level of competency required to train, assess and support care staff on an ongoing basis with regard to supporting people with complex health needs.

Good

Is the service caring?

Our findings

We spoke with people and relatives about the care they received. Everyone was positive and said they thought care staff both understood their needs and had the skills to provide the support they needed. People also felt care staff showed them respect, promoted their dignity and privacy and listened to them. People and their relatives confirmed that they felt involved in their own care, or that of a family member.

One person said, "The girls are very caring, they provide me with safe care and they look after me really well. If there is a problem you just mention it and they put it right straight away." A second person told us, "They're very good people, very caring." A third person said, "They're all very good."

One person said, "I've built up a good relationship with the group of carers over the years and my focus is the care that's provided rather than how a towel has been folded." Another relative said, "From what I have seen, the care workers are supportive of my [family member's] needs." One care worker said, "It is wrong if vulnerable people are not treated by professionals with the same respect as other patients."

We asked people and their relatives how they were involved in their care. One person told us, "I'm involved in directing my care and (in writing) my care plan." Another person said, "I'm involved in my care, I can't really go out or do very much but the carers are here and help me a lot. They will do whatever I ask of them." One care worker told us, "The client and next of kin, family members are involved in each part of creating the care plan. The information in each plan is gained form the client, next of kin and staff involved in their care. I inform management of any updates required as needed which are done and clients and relatives read, agree, or advise of any changes or errors and sign the plan before it's put into place."

Care plans were very specific in relation to directing staff to ask people, or their relatives for direction on the care and support to be provided. For example, stating, 'Please ask what I would like,' and, 'Inform my parents and they will direct you.'

A senior care worker said, "Everyone has input into care plans, people know how they want to be looked after so we liaise with the professionals. The clinical managers review care packages monthly and speak to the client and staff so we are all involved." They added, "The review of care plans are agreed by the client, family and clinical nurses." A care worker said, "As we see the service users on a regular basis we would liaise with our managers to discuss any points or changes we felt needed re-assessing within the care plan. This is because people's needs change due to lots of reasons, gaining weight, increased or decreased mobility. We are constantly aware of risk assessments and would inform management of any risks we felt needed addressing."

People and their relatives told us they were happy with the care provided. One person said, "I wouldn't change a thing; the girls give me the help I need and do whatever I ask." Another person said, "The girls do everything they should do as it should be done. If I had any anxieties I would contact the office. I try and they encourage me to be as independent as possible." Another person explained they rely on care staff, they said, "I've had help for four years and anything I need they help me with." A relative said, "My [family member]

cannot move but the girls look after her well giving her a body wash and washing her hair. Family and friends comment on how good her skin is."

There were lots of thank you cards and emails received, relatives and people were complimentary about the care provided and one relative stated, 'It takes a lot of strain and worry off our lives.' Other compliments acknowledged staff kindness and professionalism, their care, attention and love shown to people.

No one using the service currently had the involvement of an advocate but a policy was available.

Good

Is the service responsive?

Our findings

We spoke with staff about the care they provided. One care worker said, "Person centred care is when the elements of care are focused around the person being cared for and their families." They added, "At L S Care the care plans are written and discussed between the service user, their family and the staff. This ensures a person centred approach to care plans and risk assessments." Another care worker said, "It's about ensuring the client is at the centre of everything you do with and for them, this means you need to take account of their individual wishes and needs; their life circumstances and health choices."

One relative said, "[Family members] care needs change all of the time as they are growing older but the girls are great and are managing the changes." One person said, "A little while ago I felt that I needed waking care at night rather than someone being here asleep. I talked to the office about it and they have put that in place which makes me feel much better and much safer."

Care plans and risk assessments were written by the clinical managers and signed by the person. If someone was unable to sign due to their needs, their relative did so on their behalf with their agreement. The registered manager and senior clinical and training manager explained that care staff were also involved in developing care records and checking them for appropriateness.

Information in care records was very individualised and included an 'All about me' document which provided details on the person's preferred name and their family history. There was also information in relation to who had been involved in developing the care records, whether the person was able to direct their own care and who was involved in reviews. There was information in relation to things the person would like to happen, such as, 'time to myself' and things the person needed such as the use of specialised equipment. Information on what others liked and admired about the person such as, 'thoughtful, good to talk to and approachable' was documented.

Care plans included the routines people liked to follow, such as when they liked to get up, when and how they liked to have breakfast and when staff should support the person to spend time on their own, respecting their privacy. Routines were detailed in relation to the care and support staff needed to provide with a strong emphasis on how people liked to be supported. There was also information on what people were able to do independently so they were not over supported by staff.

If people used specific equipment such as hoists or specialised equipment, for example, to help the person to breathe whilst asleep, or a specialised feeding system, detailed instructions were included in care records. Staff were also trained to use each piece of equipment and had their competency assessed by a clinical and training manager.

Monthly reviews were recorded. One person said, "When we reviewed my care plan there was a discussion about reducing my care by two hours a week but I argued my point and they accepted it so things have stayed the same." A second person said, "I have regular discussions about my care." Another person said, "They come out from the office and chat about my care every now and then."

Some reviews recorded limited information that there had been no changes each month whilst other reviews were detailed. The level of detail was such that changes to a person's needs and care could be clearly identified. For one person this change in need had not been clearly updated in the care plan but there were specific instructions detailed as to the use of the new equipment. This oversight was immediately addressed and the senior clinical and training manager confirmed that the change had previously been discussed with the person and the care staff. It was evident the person had capacity and directed their own care so would have been able to direct staff to ensure their needs were met.

Care plans and routines included detail on the social activities people liked to join in with and how care staff should support people to host their visitors, attend events, or spend time enjoying a film or playing dominos together.

We asked people if they knew how to make a complaint if they were unhappy with the care they received. One person said, "I would have no hesitation in raising any issue or concern if necessary." A second person said, "If I have any issues I speak to the clinical manager." A third person said, "Things are never going to run smoothly all the time but I've no complaints." One relative said, "They've listened and it's (training) getting sorted."

Complaints record forms were used which included the date of the complaint and the date it had been formally acknowledged. There were investigation details recorded and the outcome was sent to the complainant together with an apology, if appropriate.

One person said, "I'm asked for feedback, but, to be frank and brutally honest, its half a size of A4 and very repetitive questions so I disregard it as there's no point."

There was acknowledgement from a member of staff that their feedback had been listened to and responded to. This had led to a change in staff appraisals. The staff member commented, 'It means a lot and makes a difference.'

Good

Is the service well-led?

Our findings

Everyone we spoke with told us they thought the service was well-led. One person said, "Everything is excellent – the carers and the office but I would raise concerns if I had any." Another person said, "L S Care is the best service provider we have had to date."

We asked care staff if there were any improvements they could think of. A senior care worker said, "No, not at the minute, I'm going to be involved in auditing care files, that's going to come on board soon but no concerns. If I did I would raise them. When I've raised little things in the past they have been dealt with straight away." One care worker said, "I would like to be paid when a client cancels a visit. Staff arrange their social life and family budgets around their monthly rota. When a client cancels its means staff lose out on wages and can often even cost staff money, such as child minding costs."

Regular management meetings and clinical manager meetings were held. Discussions included specific reviews of each person and any new enquiries. Training and development was also discussed.

An out of hours on-call system was in place. This meant they were able to arrange staff cover for any missed or late calls but if this was not possible the on-call staff member would cover the call. On-call also provided advice and trouble shooting in relation to any complex health care needs and equipment queries. All staff who covered the on-call system had attended the training relevant to all the people supported so they were fully aware of people's needs. The registered manager said, "Clients have the on-call number as well as our work emails and work mobiles." This meant the management team were directly available to people should they need to speak with them.

Staff meetings were held in people's homes, so they could be present and minutes were recorded in communication books so all staff had access to the records. The senior clinical and training manager said, "Team meetings can be more for people who need 24/7 care or clients wanting to request a change due to a change in need, or if there's a problem or an issue that needs to be resolved." We asked about how provider wide updates were shared with the whole staff team and were told this was completed through a quarterly newsletter sent to all staff. Training was also used as an opportunity to update staff as needed.

Quality meetings were held regularly, and attended by the management team. Agenda items included staffing, complaints and compliments, training, health and safety, documentation, accidents and incidents, and safeguarding. Safeguarding discussions included conversations around mental capacity and consent to refuse care.

Audits were completed quarterly on each person's care records and included an audit of the care plans, risk assessments and medicines. Any actions were recorded on an audit summary report and were classified as high, medium or low concern. However, there was no guidance as to how the level of concern was assessed. The audit summary report did not specify who was responsible for completing the actions nor was a timeframe specified. There was no confirmation that the actions had been completed other than reviewing the next audit. We spoke with the registered manager about this who agreed that adding information on

when the action was completed and who by would provide evidence of timeliness, and accountability, in completing actions.

We spoke with the registered manager about the management of L S Care Limited. They said, "We have made improvements to safeguarding and mental capacity. Communication is good. Our clients are happy and any issues are dealt with immediately. Clients, families, if appropriate and staff members are all involved with reviews. These are really a conversation about how it's going." They added, "We send social workers a weekly email update and raise any concerns and apologise if we are in the wrong. There are weekly visits to people by the clinical managers."

Staff told us they thought the service was well-led. One staff member said, "It's the commitment of staff and management to the service users and the service users themselves." Another care worker said, "I feel listened to but I'm not directly involved in the running of the company in a direct way but any comments I make would be discussed in the management team so I guess indirectly I am included." A senior care worker said, "The best things are a lovely friendly team. The communication is good, the best I've ever worked for if I'm honest." They added, "There's a really strong support network, it's about what everyone thinks not just one person." A care worker said there were no improvements needed and the best things were, "Excellent and up to date training." Another care worker said, "It's the people I care for. As we have clients with more complex needs, I have opportunities to learn more skills than I would elsewhere. I can't speak for others but I enjoy my job. I like the care packages I am involved in and have never had any problems with anything. I know I can contact a manager if I need to and whenever I have needed to they've sorted the problem fine."