Chameleon Care Limited

Chameleon Care (Dartford)

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 comprehensive inspection took place on the 30 January 2018 and was announced.

Chameleon Care Dartford is a domiciliary care agency, providing personal care services to people living in their own homes. This included older and younger adults and people with complex health needs such as epilepsy, diabetes, dementia and physical disabilities.

Not everyone using the service receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. At the time of the inspection, there were 37 people receiving the regulated activity of personal care from the service.

At our last inspection, the service was rated Good. At this inspection we found the service remained Good.

There continued to be a registered manager in post. 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 registered manager was supported by a manager who was based at the location and was responsible for overseeing the day to day management of the service.

People were continued to be protected from abuse and neglect. There continued to be appropriate systems in place to safeguard people from the risk of preventable harm. Risks to people and staff were appropriately assessed, mitigated and recorded.

Staff understood their responsibilities around safeguarding people from abuse and protecting their rights.

There continued to be systems in place to monitor incidents and accidents. There were arrangements in place for the service to make sure that action was taken and lessons learned when things went wrong, to improve safety across the service.

Robust recruitment processes continued to be followed and there were sufficient skilled and experienced staff to meet people's needs. We found appropriate numbers of staff were deployed to meet people's needs.

There continued to be safe systems in place for the management of medicines. Medicines were administered safely and administration records were kept up to date.

People received care from staff that had received training and support to carry out their roles.

Staff continued to have good levels of support and supervision to enable them to carry out their roles.

People's care preferences, likes and dislikes were continued to be assessed, recorded and respected, their care provided in line with up to date guidance and best practice. People's cultural and religious needs were taken into consideration at the time of assessment and reviews.

We found that there was collaborative working with other community healthcare professionals to ensure that people received coordinated and person-centred care and support. People were supported to maintain a healthy lifestyle.

Staff told us that they seek guidance from healthcare professionals as required. They told us they would speak with people's families and inform the manager if they had any concerns about people's health.

People continued to receive care from staff that were caring, kind and compassionate. People were treated with dignity and respect and staff ensured their privacy was maintained when care was provided to them.

People were encouraged to make decisions about how their care was provided and staff demonstrated a good understanding of people's needs and preferences.

Staff understood the Mental Capacity Act 2005 and how to support people's best interest if they lacked capacity. People continued to be 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.

There continued to be policies in place. People were listened to and treated fairly if they complained. The provider had a robust process in place to enable them to respond to people and their concerns, investigate them and had taken action to address their concerns.

The service had an open culture which encouraged communication and learning. People, relatives and staff were encouraged to provide feedback about the service and it was used to drive improvement.

The provider knew how and when they should escalate concerns following the local authorities safeguarding protocols. Procedures for reporting safeguarding concerns continued to be in place.

The provider continued to have processes in place to monitor the delivery of the service. People's views were obtained through surveys, one-to-one meetings, meetings with people's families and meetings with other healthcare professionals.

Staff continued to have access to an 'out of hours' support that they could contact during evenings and weekends if they had concerns about people. The service had plans in place to ensure it could run in the event of emergencies arising so that people's care would continue.

Quality assurance audits continued to be carried out to identify any shortfalls within the service and how the service could improve.

The provider and staff were committed to the values and vision of the company and they took these into account when delivering care and support.

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? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Chameleon Care (Dartford)

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 was a comprehensive inspection, which took place on 30 January 2018 and was announced. The provider was given short notice because the location provides a domiciliary care service; we needed to be sure that someone would be in the office.

The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using similar services. The inspection site visit activity started and ended on 30 January 2018. It included visiting the office location to see the registered manager and staff; to review care records and policies and procedures. We also visited one person in their own home.

Prior to the inspection, we looked at previous inspection reports and notifications about important events that had taken place at the service. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan our inspection.

During this inspection, we spoke with four people using the service and five relatives to gain their views about the service. We spoke with six members of staff. They included the registered manager, one manager, two senior support workers and two support workers. We also requested feedback from a range of healthcare professionals involved in the service. These included professionals from the local authority. We received positive feedback from one external healthcare professional.

We reviewed the care records of ten people that used the service, which included their care plans, health and medication records, risk assessments and daily care records. We also looked at the recruitment records for seven members of staff to see how the provider operated their recruitment procedures.

Other records we saw related to the management of the service and included staff rotas, training and supervision records, meeting minutes, quality audits and service user feedback. We also viewed the safeguarding, recruitment, equality and diversity, infection control, medicines, complaints and service users' right's policies.

Good

Is the service safe?

Our findings

People and their relatives told us they and their family felt safe. One person said, "The carer I have now is a top ace carer. She is marvellous. I can trust her implicitly." Another person told us, "Yes I feel safe." Comments from relatives included, "Yes, [person] is safe" and "[Person] feels safe and happy in her home and that is where she wants to be."

We found there were appropriate systems in place to prevent abuse, neglect and discrimination to people. This included staff training, relevant policies and records of referrals to the local authority and investigations. Staff told us they received safeguarding training and updates and were confident that they would know how to access the provider's safeguarding policy and procedures if needed. Staff were able to tell us about different forms of abuse when asked and said that they would report any concerns immediately to the manager. Staff were aware of whistleblowing policy and they were aware of contacts outside the provider if they needed to escalate a concern.

Appropriate checks continued to be undertaken before staff commenced work. These records included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of the person's identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

There were risk assessments in place to protect people from the risk of harm. Risk assessments identified individual risks and gave staff guidance on how to mitigate those risks to maintain people's safety and well-being. Risk assessments covered areas such as falls, pressure sores, behaviours that may challenge and medicines. For example, when it was identified that a person was at risk of developing pressure sores due to a decline in their heath and poor skin integrity, there were clear and detailed guidance in place for staff to follow, this included, daily checks, recording in the daily care records and communicating any concerns to the person's relatives and the manager, so that an appropriate referral could be made in a timely manner. These were updated regularly to reflect any changes in people's needs.

Staff continued to support people in the right numbers to be able to deliver care safely. People told us there was continuity in the care staff who supported them. People had been assessed for the numbers of staff they would need. Assessments were carried out to identify any risks to the person using the service and to the staff supporting them. Assessments completed included people's medical history, personal life history, religious and cultural needs, communication needs, environmental risks, and any risks in relation to the health and support needs of the person. Staff told us they were informed of any potential risks before they went into people's home for the first time.

We found there was an appropriate method in place for staff deployment. The registered manager explained that information was gathered from people, relatives and commissioners about a person's care needs. The care package was then designed to meet the person's needs and the allocated staff were based on the person's dependency. There was adequate travel time between calls, and in records we saw staff stayed for

the required time period for the scheduled calls. We were told there were occasionally inevitable delays in attending to people, which arose from traffic. On occasions where staff was running late, they notified the manager who then telephoned the relevant person to advise the staff member was running late. A relative told us, "We always look at the log, and it is roughly the same time that the carers come. If they are late I get a call."

There was an up to date business continuity plan in place which covered sudden unexpected short staffing. This included details of how staff should manage different kinds of foreseeable events. The provider had an out of hours on call system, which enabled serious incidents affecting people's care to be dealt with at any time.

People continued to receive their medicines when they needed them and staff followed the provider's medicines policy. People were encouraged to develop their independence around medicines. One person told us, "The staff remind me to take my own medicines." Within the relevant care records we saw that Medicine Administration Records (MARs) had been completed and information about people's individual medicines were recorded. Staff confirmed they had received training and competency checks in relation to the management of medicines. These were carried out by the manager.

People were protected from the risks of infection. We found there was good information on infection prevention and control risks in people's care files and there was evidence staff had attended appropriate training, such as food hygiene and infection control. Staff told us they always used personal protective equipment when delivering personal care and had adequate supplies.

We found lessons were learned and improvements were made when things went wrong. For example, following complaints of staff turning up late for calls, the provider increased the frequency of spot checks, a meeting took place with the staff concerned and this was also discussed in staff meeting.

The manager showed us records of safeguarding referrals or allegations, complaints and concerns, health and safety and accidents or incidents. Accidents and incidents reported continued to be reviewed by the provider and manager to ensure all appropriate steps were taken to minimise risks. Accidents and incidents recorded in the last 12 months had all been fully investigated. Staff were aware of the reporting process for any accidents or incidents that occurred. Staff said that learning points and communication about accidents, safeguarding and other incidents were discussed at regular staff meetings.

Good

Is the service effective?

Our findings

People received care from staff who had the knowledge and skills to meet their needs. People told us, "I look forward to see them", "They always ask me what I want to eat and make me a nice cup of tea" and "I am grateful for what they do for me."

People's care plans were developed prior to the start of their service and included an assessment of risks and needs. A copy of the care plan was kept on file at the office and another at the person's home. All care files were consistently organised and well maintained. This enabled staff to locate information about people easily and promptly. We found files were organised into sections which included a background; information including contacts for family, significant others, the person's GP and other healthcare professionals, medical conditions, support arrangements and schedules. The background contained important information about people's equality and diversity. We saw this included people's social history, previous employment, interests and routines, ethnicity, religious and cultural information, preferred gender of their care worker and people own views on their support needs.

The care plans were person centred and responded to people's current needs. The care plans provided clear guidance to help staff assist with the required care and support such as assistance at mealtimes, washing, dressing and mobility. We also saw a schedule of the call times along with tasks that were to be undertaken on each visit.

Staff were knowledgeable about the care and support people needed which meant that people received individualised and personalised care. Staff gave examples of how they had provided support to meet the diverse needs of people, including those related to disability, gender and faith. These needs were recorded in care plans and all staff we spoke with, knew the needs of people they supported well.

Appropriate referrals for people were made when required to other healthcare services such as GP's, mental health teams, speech and language therapists and occupational therapists. What was discussed and any actions decided were recorded by staff to ensure people received care and support that met their needs. Staff had also made good use of assistive technology to support, and to promote a people's independence when at high risk of falls, for example, by using moving and handling equipment such as hoists.

We looked at staff training records and found that staff received training to provide them with the skills and knowledge to complete their role effectively. Staff had completed training in mandatory subjects such as safeguarding, moving and handling, medication, and dementia awareness. Staff told us they received regular training and felt this enabled them to do their job well. One staff said, "We are always encouraged to develop further through training and sharing good practice."

Staff told us they received good support during their induction. They said they completed a programme of training and shadow shifts with experienced colleagues to get to know people's needs, including any cultural and religious preferences. Records showed that when new staff started they would begin training using the Care Certificate Standards. These are nationally recognised training and competency standards

for adult social care services.

Staff told us that they received regular supervision sessions with their line manager. Supervision sessions were individual meetings with their line manager to look at aspects of their role and responsibilities. Records of staff supervisions were maintained in their personnel files. Staff told us that they benefited from the supervision sessions. Annual appraisals to discuss training needs and work performance were also routinely taking place. There was a clear record of the discussion and any action points. There was evidence of input from both the supervisor and the staff.

People who used the service did not always require assistance with nutrition or hydration. Where people required support with meals, we saw there were care plans in place relating to their dietary needs and nutrition. The care plans specified the level of assistance and support needed with eating or preparation of food and recorded any particular food preferences, allergies or dislikes. The manager told us any food or fluid monitoring needs would be identified during their initial assessment and reviews. Staff told us of the importance of good nutrition and hydration for people they supported. We saw staff encouraging people to eat and drink when they carried out their visit and they made sure people had access to drinks.

Most people who used the service made their own healthcare appointments and their health needs were coordinated by themselves or their relatives. However, staff were available to arrange and support people to access healthcare appointments if needed. Staff also worked with health and social care professionals involved in people's care if their health or support needs changed. When people needed referring to other health care professionals such as GP's or district nurses, staff ensured they passed the information onto relatives or the manager so that this was organised to protect people's health and wellbeing. For example, when staff reported concerns about a person's mobility; the manager contacted the person's GP, care manager and occupational therapist for an assessment. As a result, moving and handling equipment, such as a glideabout commode, bed lever and grab rails were provided and fitted in the person's home to aid their mobility.

The Mental Capacity Act (MCA) 2005 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 2005. We checked whether the service was working within the principles of the MCA 2005.

People told us that staff always asked their consent prior to completing care tasks. Where people lacked capacity, their representatives were involved in making decisions in the person's best interest. These decisions were recorded in people's care records. All staff had received training in Mental Capacity Act 2005.

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion by the staff and the service. One person told us, "The carers are very sweet and caring and know what they are doing." Another person said, "The staff are caring and jolly. They cheer me up." A relative also agreed that the staff were caring. They said, "The carers always seem kind and respectful and mum would tell me otherwise anyway."

Staff demonstrated a caring approach to people and expressed that they wanted to provide care that met people's needs to improve their quality of life. Staff told us they had sufficient time to spend with people and listen to them. Staff knew about people's care needs and were able to explain people's preferences and daily routines. One staff said, "I follow the person's care plan all the way through" and another staff told us, "I try and understand the person and get to know them well" and "The service is person centred; there is nothing more important than the person."

During the home visit, we saw that staff responded to people in a proactive way that enabled them to predict people's mood and behaviours and reduce the likelihood of any behaviour that may challenge the service.

Staff said they understood the needs of the people they cared for and could access information by reading the individual care plans and they said they received relevant information before supporting someone for the first time. Staff were knowledgeable about the people they supported and what was important to them, such as family members and any hobbies or interests they had. Staff spoke with us about people in a dignified and professional manner. They were able to explain to us about the care and support people needed. Staff actively involved people and their relatives in making decisions and asked them what they would like.

People felt that the staff knew their routines, likes and dislikes. A person told us, "They are consistent in what they do. Also, they are happy if I need to call about a small issue. We are all on the same page, which I like." Another person said, "I am treated with number one respect by my carer. I don't want them to take her away." People told us they enjoyed communicating with the staff. One person told us, "I look forward to see them every day." Relatives we spoke with agreed that the staff from the service knew people's needs.

People's privacy and dignity continued to be protected and promoted. Staff described the methods they used to ensure that they respected people's privacy and dignity such as closing doors and curtains when delivering personal care and ensuring that people were covered up as far as possible. People and relatives told us they were satisfied with how their privacy and dignity was respected by staff.

Staff promoted personal choice and independence by ensuring that people were involved in day to day decisions regarding their care and support. One staff said, "We respect people's choices and encourage them to maintain their independence, even if it is the smallest thing like putting the kettle on." Care plans identified that people should be encouraged to do as much as possible for themselves to maintain their independence.

Staff spoke positively about working at the service. One staff told us, "I like working here; it is a good place to work." Other staff said, "It is a very nice place to work; the managers are helpful and understanding", "It is a friendly place to work" and "there is great team work; everyone pulls together and there is great support."

People's personal records were stored securely which meant people could be assured that their personal information remained confidential. Staff understood about confidentiality. All confidential information and records were kept securely in the office, so that personal information about people and staff was protected.

Good

Is the service responsive?

Our findings

People and their relatives told us they were involved in their care and support. They said they had been involved in planning their care so the support provided could meet their needs. They told us they were not worried and could talk to staff if they had any concerns. Comments from people and their relatives included, "I am quite happy. We have good communication between the both of us", "I am grateful for all they do; nothing is too much trouble" and, "One of the many things I like about my existing carer is that she thinks of things before I think of them."

People's needs continued to be fully assessed prior to admission and a comprehensive care plan was developed to meet their diverse needs. The manager told us that as part of the pre-admission process, people and their relatives were fully involved to ensure that staff had a good insight into people's personal history, their background, their individual preferences, interests and future aspirations. From this information, a personalised care plan could be put together ensuring the person was at the centre of their care.

We saw that regular updates were made and relatives and people were kept informed of any changes in people's care plans through regular review meetings. A relative told us, "They do come out and they do regular assessments." Reviews consisted of looking at all information that had been recorded over the previous months and identifying what changes if any were required to people's support and care. We noted that changes were recorded in people's care plans and assessments. Daily records were also recorded against each care area, detailing matters such as people's moods, personal care and support received and their dietary intake. Any changes made to the care plans were then shared with the staff team for their knowledge.

The provider looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People had access to an easy read complaints policy if this was required. This provided people with information about who to contact if they had a complaint and who to contact outside of the service if they were unhappy with the response given or action taken by the registered provider.

The provider had a complaints policy and procedure in place and people were made aware of this when they joined the service. People's concerns and complaints were listened to and responded to, and feedback received was used to improve the quality of care and support people received. People felt comfortable in raising complaints with staff or the provider. One person told us that they had raised a concern about a member of staff and that they had since been removed from their rota.

The complaints records showed that three complaints had been received in the last year. There were procedures in place to deal with complaints effectively, records were fully completed, investigated and responded to appropriately. The registered manager shared the learning with the staff team, in staff meeting

and one to one meetings, with the aim to make improvements at the service.

The provider had received a number of verbal and written compliments which were also recorded and shared with staff. Comments from these included, '[…] found the staff to be caring, reliable, helpful and will miss them all', 'Cannot thank staff enough for their kindness, staff are professional, caring and cannot find the words to describe how much they helped when [person] was on end of life care' and 'Thank you to all staff for being friendly and completing all tasks as requested, and making me feel at ease.'

Good

Is the service well-led?

Our findings

People and the relatives we spoke with were positive of the staff and management team. One person said, "[Provider] is very good", "Both [provider and manager] are very approachable". Another person told us, "The chain of communication is very good." A relative told us, "We work together on things."

The registered manager was also the provider. The management team included the registered manager, a senior manager, and a manager. The manager was based at the location and was responsible for overseeing the day to day management of the service.

The provider was familiar with their responsibilities and conditions of registration. The provider was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team when required. They understood their obligation in relation to submitting legal notifications to the Commission. The Provider Information Return (PIR) we requested was completed within the specified time frame.

The provider had a clear vision, which was to support people to receive high quality care and support. We saw that the culture of the service promoted person centred care which was open, inclusive and empowering for the people using the service. People we spoke with indicated that they had had appropriate opportunities to provide feedback to the service and had received survey forms. One person said, "Yes, we occasionally get questionnaires to fill out and to give back."

The manager carried out regular visits to people to gain their feedback. The manager said, "I keep in touch with people and their relatives. I also cover care calls at the weekends and cover staff sickness." We saw that spot checks also took place. These were visits from the manager to people's homes to assess the quality of the support provided. They checked that staff were dressed appropriately; wearing personal protective equipment such as gloves and aprons. The checks also included looking at people's care records to ensure these were fully completed and meeting people's current needs. These were fully recorded and feedback provided to the staff team.

Staff understood about people's needs and feedback from people and relatives was positive and showed good standards of care were provided to people. For example, 100% of people who responded said the service was meeting their needs, their privacy was respected and they were treated with dignity.

Staff were supported through regular supervision and received appropriate training to meet the needs of people they cared for. Staff felt valued and enabled to contribute to the development of the service through regular team meetings. Minutes of these meetings showed that various issues relevant to staff's roles were discussed. Staff told us, "The manager is approachable, helpful, supportive and flexible", "We see the provider often; he comes to the office regularly and is approachable" and "The managers are helpful and understanding; we can also have a laugh and a joke."

The provider had effective systems to assess and monitor the quality of the service. The provider completed

regular audits and took appropriate action to rectify any shortfalls in a timely way. For example, in the most recent audit, the provider identified that some of the care plans required updating, with in depth information on pressure ulcer care. We checked and saw that this had been actioned and the relevant care plans had been updated with the information.

The provider continued to work closely with health care professionals, social workers, referral officers, district nurses, speech and language therapists and occupational therapists. This ensured the right support and equipment were secured promptly and helped people continue to live independently, safely or be referred to the most appropriate services for further advice and assistance when this was necessary.

Policies and procedures relating to the running of the service were easily accessible to staff. All policies had been reviewed and maintained to ensure that staff had access to up to date information and guidance to support them within their roles.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating at the service and on their website.