Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Independent Home Living (Beverley)

61 Eastgate, Beverley, HU17 0DR

Tel: 01482882997

Date of Inspection: 15 April 2013

Date of Publication: May 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	A New Angle Limited
Registered Manager	Mrs. Alison Thompson
Overview of the service	Independent Home Living is a domiciliary care agency that is based in Beverley, in the East Riding of Yorkshire. The head office for the organisation is in Scarborough, North Yorkshire. The agency provides personal care and support to people who live in their own home. The service is provided in the towns of Beverley and Driffield and the surrounding villages. The care manager is based at the Beverley branch and the registered manager is based at the head office in Scarborough.
Type of services	Domiciliary care service Supported living service
Regulated activity	Personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 15 April 2013, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We spoke with the care manager and the office manager on the day of the inspection and telephoned two care workers and two people's carers the following day.

We received positive comments from the carers of people who received a service from the agency. One person said, "I cannot fault the carers" and another said, "We can choose which agency to use and we would change to another agency if we were not satisfied, but we have been".

People told us that they received a service from a small number of care workers and did not express any concerns about inconsistency, missed calls or lateness. They said that they were consulted about the care they received and were satisfied with the support they received with the administration of medication.

Care workers told us that they received appropriate training that equipped them to carry out their role effectively.

There were quality monitoring systems in place that gave people who used the service, their carers and care workers the opportunity to express their views and affect the way in which the agency was operated. Care plans were audited and complaints were responded to appropriately. More robust recording of complaints and accidents/incidents would allow areas for improvement to be identified and acted on.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent

judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

We spoke with the care manager on the day of the inspection. They told us that they visited each person who requested a service from the agency. They discussed with the person their specific care needs and used this information to develop an individual plan of care or support.

The care manager showed us new documentation that had been introduced within the organisation. We saw that both the client information form (care plan) and the medication form included areas for the person who received a service to sign, so that they could acknowledge their agreement to their plan of care, although those that we saw had not been signed. The manager told us that this was because all care planning documentation had recently been updated and some documents still needed to be signed by people who used the service. She said that, within the new care planning system, people would be asked to sign their care plan, the details of the hours needed to provide their package of care, their contract with the agency and a medication form.

We saw a confidentiality consent form that was given to people with their introductory pack. People signed this form to agree to the agency holding information about them and to consent to the agency sharing information with health and social care professionals when required.

The people who received a service told us that they had regular carers who knew them well and who understood their needs and wishes. People told us that care workers always asked, "Is there anything else I can do for you". One carer said, "The care workers check things with me first" and another person's carer told us, "They don't take over – they wait for instructions from my spouse".

Care workers told us that they attended a regular group of people so got to know them well. They said that people who used the service were involved in developing their own care plan and that, when they visited, they asked if there were things people would rather do themselves or anything else they could do to help them.

We requested information from the organisations head office on the day of the inspection regarding the content of induction training. We were told that staff complete training on safeguarding adults from abuse and that this training included information on dementia and the Mental Capacity Act 2005. The care workers who we spoke with displayed an understanding of the issues regarding consent and a person's capacity to make decisions, as well as a person's right to make their own decisions when they had the capacity to do so.

The care manager was able to explain situations where they had requested an assessment in respect of a person's capacity to make decisions, where they had contacted the safeguarding adult's team with concerns and where solicitors had been involved in a person's welfare to protect them from the risk of financial abuse.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

During our visit to the agency office we examined the care records for three people who received a service from the agency. We saw that the care manager had undertaken assessments regarding a person's support needs. This included information about their medical history, medication, family relationships, social activities, any equipment used in the home and their personal care needs. Any risks identified during the assessment process had been recorded in a risk assessment. We saw risk assessments for areas such as security, storage, slipping/tripping and fire safety. The level of risk was determined and, where a risk was considered to be 'high', a more in depth risk assessment had been undertaken; this was primarily for people with mobility needs.

Anyone who required assistance with medication had a separate risk assessment in place. Care workers told us that some people needed prompting to take their medication and some people needed assistance to take their medication. The form that we saw recorded these details.

Assessment and risk assessment information had been used to develop an individual plan of care. Care plans recorded details of the tasks people would require assistance with at each visit. When people had several visits each day, the information had been divided into breakfast, mid-morning, lunch, afternoon, tea/dinner and evening calls. Each time slot recorded specific information about the support to be provided, for example, "Assist with washing and dressing. Cleanse, tone and moisturise face". All of the people that we spoke with told us that they received the service that had been agreed with them. One person's carer said, "I cannot fault the carers" and another said, "We have a small team of carers who know my spouse well. They encourage them to do as much as they can for themselves".

Care workers who we spoke with told us that, when they were asked to visit a new service user, they were sent information via their mobile telephones regarding the person's specific care needs; the organisation had provided each member of staff with a mobile telephone that was attached to a database which recorded service user information. We

also saw that information sheets about any illnesses the person had were included in care plans to assist care workers with understanding specific medical conditions and providing more appropriate care.

Care workers said that, if the person was a new service user, they were taken to the person's home by the manager so that introductions could be made whenever this was possible. The care manager told us that staff were paid by the organisation for carrying out this introductory visit and that it was at this stage that the care plan folder was taken to the person who would be receiving a service. Care workers told us that, if they were visiting an existing service user for the first time, they might 'shadow' the current care worker so that they could get to know the person and their routines.

We saw copies of diary sheets in the care plans we viewed and noted that care workers recorded the date, their name, the time they had arrived at the person's home, the details of support provided during the visit and the time they left the person's home. We saw that diary entries were detailed and recorded the tasks they had undertaken and how the person had been during the visit. Care plans also included a 'client communication sheet' that recorded any particular events or concerns such as GP visits or referrals to health or social care professionals so that this information was easy to identify for care workers.

None of the people who we spoke with raised any concerns about care workers being late or missing calls. The care manager showed us a system on the database that identified calls that needed covering urgently if someone went off sick so that they could be prioritised. This ensured that people with dietary, medication and personal care needs received the consistent support they needed.

Care workers said that they would contact the agency office if they felt that the current care package was no longer meeting the person's needs or that their care needs had changed. They told us that office staff would act on this information and in some instances would visit the person concerned to reassess their needs. The care manager told us that the organisation had recently decided that they would hold meetings for the core group of staff attending someone when their care needs had changed, and that staff would be paid for attending these meetings. We saw that one of these meetings was planned for the following day.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Medicines were handled appropriately. The care manager told us that all staff had undertaken training on the administration of medication as part of their induction training. The staff records that we saw on the day of the inspection and the care workers who we spoke with confirmed this. Care workers told us that the training they had undertaken provided them with enough information to carry out this task safely.

We spoke to two carers of people who had help with the administration of medication. They were aware that the staff had received training and said that they had no concerns about the staff's ability to carry out this role. One person said, "The system runs smoothly and it feels safe".

Appropriate arrangements were in place in relation to obtaining and the recording of medication. The care manager explained that some people had their medication delivered by the pharmacy, some medication was collected by relatives and other medication was collected by care workers. All of the people who were assisted with the administration of medication had most of their medication supplied in a Nomad pack, a packaging system that held a person's medication separately for each time of administration on each day.

The care manager told us that most people were able to check the content of the Nomad pack themselves or had a relative who could do this for them. She said that the medication contained in each person's Nomad pack was recorded in their care plan. Although staff checked the content of Nomad packs for some people, the responsibility for ensuring that the medication in the Nomad pack was correct was with the pharmacist. However, the care manager said that a 'regular' carer was always responsible for overseeing medication and would 'pick up' any discrepancies. Staff administered the content of the pack and signed to say that they had seen the person take that medication.

We saw an example of a medication administration medication (MAR) chart that was used by care workers. This included instructions for care workers on the administration of medication, such as, "Always ensure that the Nomad system is for that particular client. Check you have the correct date and time. Please ensure that the client has taken all their medications when prompted".

The care manager was able to inform care workers if someone had been prescribed a new medication immediately by contacting them on the system incorporated into their mobile telephone. The care manager told us that it was the agency's policy for care workers not to administer medication if they noticed any discrepancies until they could be checked out with the pharmacist or GP and that, similarly, they did not act on instructions from family members until the information could be checked with the pharmacist or GP.

The details of any medication supplied separately to the Nomad were entered on to the MAR chart by the care worker attending on that day. The provider may wish to note that there was no second signature on the MAR chart to evidence that the details entered by one care worker had been checked by another care worker to reduce the risk of errors occurring. The care manager told us that staff were trained to administer by checking information on the medicine packaging and not the MAR chart. However, she agreed that a double signature would provide a more robust system and said they would incorporate this into their current procedures. We saw that the MAR chart included details of the codes to be used on occasions when medication had not been taken.

The care manager told us that care workers who had responsibility for collecting medication from the pharmacy also had responsibility for returning unused medication.

The care manager told us that people with a memory impairment were supplied with a lockable storage box or safe where medication could be stored, and that these were kept 'out of sight' unless families requested otherwise. The keys for the storage boxes were kept in key safes to promote security.

If someone was admitted to hospital when the care worker was present, they took their Nomad and MAR chart with them to promote continuity. On discharge, the care manager would ring the hospital to ask if any changes had been made to the person's medication to ensure that the details held in the person's care plan were up to date.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Staff received appropriate professional development.

The staff who we spoke with told us that they received sufficient training to enable them to carry out their roles effectively. They told us that they had supervision with a manager and that they attended staff meetings. However, staff told us that they could also go into the office at any time and speak to the care manager. They said that if they discussed any additional training needs with the care manager, they were confident that every effort would be made to source this training for them.

The care manager told us that all staff attended a five day induction training course when they were new in post. If they had no previous experience of working in a care setting, they were required to undertake this training prior to working with people unsupervised. If they had previous experience and were able to evidence this by producing training certificates, they had a brief in-house induction, shadowed current care workers and were introduced to the people who they were supporting. They were then able to start work and undertake induction training when the next course became available.

The induction training programme covered a variety of topics including safeguarding adults from abuse, principles of care, bathing, infection control, communication skills, dementia awareness, pressure care, food hygiene, health and safety, first aid, medication and record keeping. The care manager told us that some additional training was provided by the agency. This included fire safety and restraint/management of challenging behaviour.

The agency had a policy in place to record when care workers required refresher training. For example, care workers were expected to attend moving and handling training every 18 months, medication training every year and safeguarding adults from abuse training every two years. The care manager said that care workers were told when they had to attend this training rather than having to request it. The provider may wish to note that there was no overall training matrix that recorded the training completed by staff. This would have provided an overall record of the training needs and achievements of staff and would have evidenced that staff had undertaken refresher training at intervals agreed by the agency.

We checked the individual training records for a member of staff. We saw that there was a

record of the care workers five day induction training and that the care worker had signed a document to evidence that they had received a copy of the emergency moving and transfer protocol. The records also included information about two recent spot checks that were undertaken at the home of someone who used the service. Spot checks were undertaken both to check the performance of the care worker and to give the person who used the service an opportunity to share their views on the quality of the service they received. The care manager told us that care workers also received an annual appraisal.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider was meeting this standard. The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

The registered person told us that they had recently sent out questionnaires to people who used the service and the people who we spoke with confirmed this. The care manager said that when all questionnaires had been returned, the administrator would collate the responses and prepare a spreadsheet. Any areas of improvement would be identified and discussed at the next manager's meeting and all care workers would receive a copy.

We saw that one of the questions asked in the questionnaire was, "Can you recommend how we might improve our service?" This gave people who received a service from the agency an opportunity to give feedback about their level of satisfaction and to make suggestions for improvement. We noted that people could return their questionnaire anonymously if they preferred.

The care manager told us that each new service user received an information pack that included a support plan signatory list (this was signed by each care worker who visited the person to evidence that they had read the care plan), a client information form (care plan), a contract, the schedule of visits agreed, a medication consent form, a client charter, information about the Data Protection Act 1988 and a confidentiality consent form. People signed this form to agree to the agency holding information about them and to consent to the agency sharing information with health and social care professionals when required.

The care manager told us that an audit of care plans undertaken by the training officer had identified that some of the new documentation in care plans had not been signed by people who used the service to evidence their consent/agreement. As a result, all care plans were in the process of being reviewed and the care manager was visiting each person who received a service to discuss the content of their care plan and request that they signed the relevant documents.

The care manager said that, as a result of these audits, the organisation had agreed that they would be repeated every month to monitor compliance. The provider may wish to

note that these care plan audits had not been recorded so there was no record of the action required, details of when the records would be re-checked and when the action had been completed.

The care manager told us that they held staff meetings; these had been annual but the agency had recently decided to increase these to six monthly. The most recent meetings had been on 12 and 14 March 2013. The care manager said that two meetings were arranged to enable more staff to attend, and care workers told us that they received minutes of the meeting if they were not able to attend. We saw that the topics discussed included confidentiality, promoting independence, personal protective equipment, spot checks and schedules. These meetings gave staff the opportunity to share their views with managers and to discuss any concerns about the people they supported.

Manager's meetings were also held every three months. This gave managers from each agency the opportunity to meet to share good practice and promote consistency.

We checked the accident book and saw that there had only been one accident in the previous twelve months. This had been recorded satisfactorily and the care manager had arranged to visit the person concerned to update their risk assessment. There had only been one accident in 2011 and one accident in 2010. The provider may wish to note that, although only a small number of accidents had occurred, there was no system in place to audit accidents and incidents to identify patterns or areas for improvement.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

People's complaints were fully investigated and resolved, where possible, to their satisfaction.

The care manager told us that each person received an information pack when they started to use the service. We saw that this included information about comments, compliments and complaints. This document stated, "When the problem has been resolved you will receive a written response, seeking agreement from you that the complaint has been resolved to your satisfaction". The provider may wish to note that there was no timescale recorded in the policy to inform the complainant when they could expect to receive a response from the agency.

There had been one written complaint received during the previous year. The care manager told us that this information was held at the head office, as the complaint had been primarily about financial issues. The care manager told us that some changes had been made to policies and procedures following the complaints investigation undertaken by the agency. These included that the agency would only begin a care package commissioned by the local authority when they had received a contract and that they would investigate unpaid invoices promptly.

We saw that any verbal comments or complaints received by the agency were recorded on the database with the person's care planning documentation. The provider may wish to note that, although only a small number of complaints had been received, there was no central record of the complaints received and no system in place to audit complaints or concerns so that the organisation could identify patterns or areas for improvement.

The two carers who we spoke with told us that any issues they had raised with the agency office had been dealt with in a satisfactory manner. One person had not been happy with one of the care workers who visited them; they informed the agency office and they agreed that this care worker would not visit them again. One person's carer said, "We can choose which agency to use and we would change to another agency if we were not satisfied, but we have been". Another person's carer said, "They do their best to put things right".

The care workers that we spoke with said that they would encourage people to make a complaint if they felt that they were justified in doing so. They said that people who used

the service received information about how to make comments or complaints and that they were certain they would contact the agency office if they were dissatisfied.

We saw numerous letters of thanks that had been sent to the agency office from people who used the service and/or their relatives.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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