Adina Home Care Services Ltd

Adina Home Care Services

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

Adina Home Care Services provides a range of services to people in their own home including personal care. People using the service had a range of needs such as learning and/or physical disabilities and dementia. At the time of our inspection 41 people were receiving personal care in their own homes.

Not everyone using Adina Home Care Services receives a regulated activity. CQC only inspect the service received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they were safe. There were safeguarding systems and processes to support care workers to protect people from avoidable harm. Care workers underwent appropriate recruitment checks before they started to work at the service. At this inspection, the service had ensured there were sufficient staff to meet people's needs safely. This also included needs of people related to support with medicines and hygiene.

Care plans were detailed and person-centred. People had their needs assessed across a wide range of areas and care plans included guidance about meeting these needs. Care workers understood the Mental Capacity Act 2005 (MCA). The service was aware of the need to assess people's capacity to make specific decisions. Care workers were supported to have the skills and knowledge to carry out their role. They had received an induction and essential training. People were supported to have sufficient amounts to eat and drink.

Care workers told us that the registered manager was supportive. They had received regular supervisions and appraisal. Spot checks were also a regular occurrence to monitor performance. People who used the service told us that staff were kind and caring.

People and their relatives were involved in their care. Care workers knew people well and could describe to us how people liked to be supported. The service shared with us many good examples of person centred care. There was a complaints procedure which people and their relatives were aware of. People felt they would be listened to if they needed to complain or raise concerns. The Accessible Information standard was understood by the management team.

The registered manager was knowledgeable about issues and priorities relating to the quality and future of the service. There were effective governance arrangements. There were systems to assess, monitor and improve the quality of the service provided.

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. There were safeguarding systems and processes to protect people from avoidable harm.

Risks to people were minimised because there were effective systems and processes in place.

Care workers had been recruited safely. They underwent appropriate recruitment checks before they started to work at the service.

The service had processes in place to reduce the risk of infection and cross contamination.

There were systems in place to ensure people were supported with their medicines. Care workers had received medicines training.

Is the service effective?

Good

The service was effective. People's needs had been assessed before they started to use the service. Care plans included guidance about meeting these needs.

Care workers understood the Mental Capacity Act 2005 (MCA).

Care workers received an induction before they could provide care to people. Regular training and support were provided continuously.

Care workers received monthly supervisions, regular spot checks and an annual appraisal.

People were supported to have sufficient amounts to eat and drink.

Is the service caring?

Good

The service was caring. Care workers had a good understanding of protecting and respecting people's human rights.

They understood the importance of treating people fairly, regardless of differences.

The service recognised people's rights to privacy and confidentiality.

People were supported to maintain their independence.

Is the service responsive?

Good

The service was responsive. People told us that they received personalised care that met their needs. We saw good examples of person-centred care throughout the inspection.

Care workers were knowledgeable about people's needs and could describe how people liked to be supported.

Care plans were regularly reviewed to ensure they reflected people's changing needs and wishes.

The service had a complaints procedure which people and their relatives were aware of.

Is the service well-led?

Good

The service was well-led.

The registered manager had the knowledge and skills to deliver good quality care.

The registered manager was knowledgeable about issues and priorities relating to the quality and future of the service.

A range of quality assurance processes such as surveys, audits, accidents and incidents and spot checks had been used continuously to drive improvement.

Adina Home Care Services

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.

We gave 48 hours' notice to be sure the management would be in the office and available to assist with the inspection.

This inspection took place on 22 June 2018, and was undertaken by one adult social care inspector.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law.

During the inspection we spoke with two people using the service and nine relatives to obtain feedback about their experiences of the service. We spoke with the registered manager, operations manager and five care workers. We examined six people's care records. We also looked at personnel records of seven care workers, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including staffing rotas and quality assurance processes, to see how the service was run.

Good

Is the service safe?

Our findings

People receiving care told us they felt safe in the care of staff. This was also confirmed by their relatives. One person told us, "I feel safe from abuse or harm when receiving care from my care worker." Nine relatives of people receiving care also shared the same view. They told us that people were safe.

There were safeguarding systems and processes to support care workers to understand their role and responsibilities to protect people from avoidable harm. There were relevant policies in place, including safeguarding, whistleblowing and harassment. Care workers had received safeguarding training. They were aware of how to raise concerns through these policies and were confident any concerns raised would be dealt with effectively to make sure people were protected. Care workers were also aware they could report allegations of abuse to the local authority safeguarding team and the Commission if management had taken no action.

There were effective systems and processes in place to minimise risks to people. Support plans included risk assessments covering a range of areas, including moving and handling, falls, pressure sore management and medical conditions such as diabetes and epilepsy. There was information to guide staff members when delivering support to people, including how to reduce identified risks. For example, one person was at risk of developing pressure ulcers and their support plan contained a set of instructions to reduce the risk. These included, an air mattress and cushion to relieve pressure, regular repositioning every three hours during the day and four hours during the night and any skin damage to be noted and documented on a body map. There were also instructions for care workers to inform CQC and the local authority safeguarding team should a grade three or four pressure ulcer develop. The risk assessments were reviewed on a monthly regular basis, which ensured people's safety and wellbeing were monitored and managed appropriately.

Environmental safety was also considered. The CQC has no regulatory powers or duties to inspect people's own homes. However registered providers have responsibilities in relation to the environments people who use the service lived in. The service carried out an environmental risk assessment of the home at the first contact with the person. The assessment covered a range of areas, including trip hazards, fire safety, and moving and handling. Where risks were identified, there were specific actions to take to reduce the risk. For example, the service had made arrangements on behalf of a person who required bedrails for their safety. Care workers were instructed to carry out regular checks on the environment to reduce the risk to people in their own homes. The registered manager was aware they could contact relatives, landlords or alert local authorities for any maintenance work.

Care workers had been recruited safely. They underwent appropriate recruitment checks before they started to work at the service to ensure they were suitable to provide people's care. Pre-employment checks had been carried out to make sure new care workers were of good character to work with people. Checks included, at least two references, proof of identity and Disclosure and Barring checks (DBS). The DBS helps employers make safer recruitment decisions and prevent the appointment of unsuitable people. These checks helped to ensure only suitable applicants were offered work with the service. We noted that one care worker with issues associated with their recruitment application had been risk assessed and there were

special supervision arrangements following their appointment.

There were sufficient care workers deployed to keep people safe. An electronic scheduling and monitoring system was in place to manage staff shifts and absences. However, even with this system in place, we received conflicting feedback from people. Most people told us care workers were always on time. One person said, "Care workers can be late by 5 or 10 minutes. Only once in the last six months was the care worker 30 minutes late." A relative told us "We have only just started using the agency. They are normally on time." We spoke to the registered manager and they told us that they had reviewed their staffing after a few months of operating. They had increased their staffing following feedback from people. They had also put other measures in place to improve punctuality, including allocating extra time to those who use public transport, and pairing staff between those who drive and walk to ensure that at least one care worker arrives on time.

There was a process in place to monitor any accidents and incidents. Care workers confirmed they were aware of this. The registered manager explained all accidents were logged centrally to ensure management oversight over any emerging trends. There was evidence that accidents were discussed in staff and management meetings to identify any trends and to ensure appropriate action had been taken. The service had a few incidents of staff lateness and this had been addressed.

People were protected from the risks associated with poor infection control because the service had processes in place to reduce the risk of infection and cross contamination. Care workers had completed training in infection control prevention. There was an infection control policy which provided guidance in line with national guidance from the National Institute for Clinical Excellence (NICE) guideline 2012: Preventing infections in people having treatment and care at home or in the community. Care workers were supplied with appropriate personal protective equipment (PPE), including gloves and aprons, when they supported people.

In another example of good infection control practice, the service had taken proactive action to prevent cross contamination. A person discharged from hospital with a diagnosis of MRSA (Methicillin-resistant Staphylococcus aureus) had become MRSA free whilst being cared for by the service. The service had an MRSA policy, which the registered manager told us they followed to prevent spread of the infection, including good handwashing practices. The service had also minimised chances cross contamination by changing call times so that care workers working with the person did not have subsequent calls.

There were systems in place to ensure proper and safe use of medicines. Care workers had received medicines training. There was evidence they had been trained and assessed as competent to support people to take their medicines. There was a medicines policy which provided guidance in line with national guidance from the National Institute for Clinical Excellence (NICE). People told us their medicines were safely managed.

Good

Is the service effective?

Our findings

People's needs had been assessed before they started to use the service. Assessments covered areas such as nutrition, moving and handling, communication, health and safety, and relevant medical conditions. Care plans included guidance about meeting these needs. People gave us positive feedback about how the service was meeting their needs. One person told us, "My needs are met. Care workers always ask me if there is anything else they can do. They make sure I am comfortable before they leave." Relatives were also as complimentary. They told us, "Care workers respect my relative's dietary needs" and "The two care workers who are supporting our relative are good. I spoke to the manager as I want to keep them." A compliment from one relative read, 'Since we started the care package with your agency, my relative has been very happy and settled. Your commitment to providing the best care for her has been invaluable'.

As part of meeting people's needs, the service worked with a range of health and social care professionals. People told us staff accompanied them or arranged visits to hospitals and appointments with GPs. We noted good examples of this. In one example, a person was admitted into hospital for four weeks for injuries sustained following falls. When she was to be discharged the agency worked with the family and occupational therapist to make reasonable adjustment to the person's home. Also, the service suggested sleep-night calls. As a result, no falls had been reported since her discharge from hospital. In another example, a care worker noticed some bruises on arms and legs of one person. This was reported to the GP who arranged blood tests. It turned out this person had been discharged from hospital without their blood thinning medicines following treatment. Because of the action of this care worker, the person was attended to on time, and was treated with an anticoagulant and a scan was carried out, which confirmed no harm had occurred.

People's rights were protected because the registered manager ensured that the requirements of the Mental Capacity Act (MCA) 2005 were met. The 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 to receive care and treatment when this is in their best interest and legally authorised under the MCA.

People who were unable to make decisions about their care had been assessed in line with the MCA 2005. They were supported to participate in their care and to make decisions about their day to day lives. People told us care workers consulted with them during visits. We examined people's records, which confirmed that decisions had been made in their best interests and by whom. One person told us, "I am involved in the decisions regarding my care and support needs." This view was backed up by nine relatives, who represented nine people receiving care. Where appropriate the service had involved families and professional representatives to ensure decisions made were in people's best interests.

Care workers were supported to have the skills and knowledge to carry out their role. They had completed an induction programme according to the Care Certificate framework. The Care Certificate is an agreed set

of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. New care workers shadowed experienced members of staff until they felt confident to provide care on their own. Furthermore, there was on-going essential training, including communication, duty of care, equality and diversity, first aid awareness, fluids and nutrition, food hygiene, handling information, health and safety, safeguarding and medicines handling. Records confirmed care workers were up to date with their training. Where refresher training was due this had been scheduled. A relative told us, "The care worker I have is well trained and kind. I cannot speak for the rest of the agency but I would give them 8 out of 10."

Care workers received monthly supervision. They received quarterly spot checks with an annual appraisal. Care workers told us supervision provided an opportunity for a two-way conversation with their manager about their role. We saw evidence the registered manager explained priorities and objectives with care workers at the beginning of the year. This was revisited midyear to discuss progress and any learning needs. This was then reviewed at the end of the year. A staff member told us, "My learning needs are constantly reviewed. The manager is supportive of me." This view was generally shared by staff we spoke with.

People told us care workers were available to make sure they had enough to eat and drink. In some examples people's relatives prepared their meals. However, where required, care workers supported people to prepare and eat their meals. There was a nutrition and hydration policy to provide guidance to staff on meeting the dietary needs of people.

Good

Is the service caring?

Our findings

People and their relatives told us that care workers were caring. They described care workers as kind, compassionate, caring, and respectful. Their comments included, "We only have one care worker. She is great and is caring and kind", "Our care worker is kind and caring. She speaks Gujarati. They respect our religion" and "Care workers are kind and caring. Some go over and beyond. They have a good relationship with my relative. They have a laugh and a giggle. They always make sure she is safe when they are out. If they are on the bus, they might have to wait for a pram to get out of the way'.

We confirmed this feedback from speaking with people and their relatives. Care workers had a good understanding of protecting and respecting people's human rights. They had received equality and diversity training. They understood the importance of treating people fairly, regardless of differences. They were aware of people's right to privacy, dignity and respect. The service had relevant policies in place, including, equality and diversity. The Equalities Act 2010 was also in place.

There were arrangements for gaining access to people's homes, whilst maintaining privacy and ensuring people's safety. People told us care workers knocked on doors before entering their homes. Care workers told us that they ensured people were covered up during personal care and enabled them to be as independent as possible. Equally, the service was mindful of the information they received about people. It recognised people's rights to privacy and confidentiality. Care records were stored securely in locked cabinets in the office and, electronically. The service had updated its confidentiality policies to comply with the new General Data Protection Regulation (GDPR) law. The GDPR law came into effect on 25 May 2018. It is Europe's new framework for data protection laws. It replaced the previous 1995 data protection directive.

Care workers were knowledgeable about people's preferences. People's care records contained their profiles, which recorded key information about their care. This included people's likes and dislikes, gender, interests, culture and language. This information enabled care workers to involve people as they wished to be. As a result, we saw that rotas were organised so that people received care, as much as possible, from regular care workers. For example, some people attended church services and the service had considered this when deciding on which care workers will be working with them.

People were supported to maintain their independence. Their care records contained information about their choices and independence. Care workers knew each person's ability to undertake tasks related to their daily living. Care workers were encouraged to take time to support people to participate as fully as they could. Relatives told us the service encouraged people to be independent. Their comments included, "Care workers only prompt me but I take my own medicines." This shows people's independence was encouraged, "My relative has dementia. The care workers prompt him to help himself as well" and "My relative is assertive and she tells the care workers what she can do and what she wants to do."

Good

Is the service responsive?

Our findings

People told us that they received personalised care that met their needs. One person told us, "My needs are met. No problem whatsoever." This was also confirmed with the relatives we spoke with.

Care workers were knowledgeable about people's needs. They knew people well and could describe to us how people liked to be supported. Care workers confirmed they had been allocated to the same people, which helped them to be more familiarised with people's individual needs. We asked people if they received visits from the same care workers. Overall people reported that they had regular care workers. One person said, "We have the same care worker every day for the last few months. They do send someone else if he has a day off. My care worker is really good." A relative said, "We have two different care workers that go out with my relative and a third who attends to personal care. It works 95% of the time."

However, some of the feedback received highlighted some previous concerns with staffing changes. For example, a relative said, "We do have a regular care worker. The present care worker is my relative's favourite. She is very good. The service was very erratic to start with." We spoke with the registered manager regarding this feedback and they acknowledged that their staffing had improved. Therefore, the service should maintain the current improvements.

People received care and support that was responsive to their individual needs. There was evidence that the individual and in some examples, relatives or friends, were involved in providing information about the person. Care plans were tailored to meet people's individual needs. They were regularly reviewed to ensure they reflected people's changing needs and wishes.

Throughout this inspection we saw good examples of person-centred care. In one example, a person who attended a specific Pentecostal church on Sundays was matched with a female care worker who attended the same church. The person commented that they were happy that their spiritual needs were being met.

In another example, the service demonstrated they were responsive to people's needs. They provided staff at short notice to a person who had been admitted into hospital for day surgery. Whilst in hospital, the person had requested for a night care worker. This was necessary to facilitate discharge after the day surgery. We read feedback from the person commending the service for their responsiveness.

In a third example, one person using the service became bed bound due to a pressure ulcer that had been sustained on the heel. This had been reported to the GP, and referral made to the district nurse. However, this had not been promptly attended. The registered manager, who is also a qualified nurse, undertook a reassessment, which concluded that an additional care worker was required and this was agreed by the local authority. Furthermore, the service introduced a turning chart and catheter care was taught to care workers to prevent infection.

Individual communication needs were assessed and met. The service had an Accessible Information Standard (AIS) policy in place. From 1 August 2016, providers of publicly-funded adult social care must

follow the AIS in full. Services must record, flag, share and meet people's information and communication needs. We saw that the service was complying with these requirements. Each person's preferred method of communication was highlighted in their care plans, which showed people's communication needs had been considered. In one example, a person receiving care had been matched with a care worker on grounds of a mutual language and religion. The service had received a compliment from a relative stating, 'Thank you for making sure my relative has a Tamil speaker to care for her. This has made her mental well-being far better than it was. She used to get agitated and stressed when someone who did not speak her language entered her room'.

The service had a complaints procedure which people and their relatives were aware of. The procedure explained the process for reporting a complaint. The service had not received any complaint. People told us they were aware they could call the office or speak with care workers if they had any concerns. They felt they would be listened to if they needed to complain or raise concerns. Relatives commented that when they made suggestions, these had been received and responded to positively.

Good

Is the service well-led?

Our findings

We asked people and their relative if they knew the manager at the service and what they thought about how the service was managed and they thought the service was well-led. One person told us, "I would give them 9 out of 10." A relative told us, "The service is well-led. I would give them 10 out of 10." Another relative said, "Previously my relative was with another agency. It was pure hell. It is refreshing to be with Adina Home Care Services."

Feedback from some relatives showed that the service has had to make some improvements since it started to operate. One relative told us, "They are a fairly new agency. They needed time to get things in place. At the beginning I would have given them 2 out of 10 but now I would give them 7 out of 10." Another relative said, "We can't complain now. I would give them 9 out of 10. At the beginning I would have given them 5 out of 10."

The registered manager had capacity and skills to deliver good quality care. She was a qualified nurse and had specialised in renal as well as dementia care. We saw that she was using her nursing skills in delivering care to people using the service. Care workers told us that the leadership of the service was good. They confirmed that the registered manager was approachable and that they could contact her at any time for support.

We found the registered manager to be knowledgeable about issues and priorities relating to the quality and future of the service. She understood the challenges and was addressing them. For example, we saw that the service had rapidly expanded by proving care to a number of people within a short space of time. This in turn had placed pressure on resources available. At that time, the service had not matched the number of people receiving care to staff available. This had increased demands on individual staff, leading to lateness and a high staff turnover. The registered manager had quickly recognised this and reviewed the business plan and risks to ensure that the resources complimented the number of people receiving care.

At the time of this inspection we saw that the registered manager had taken steps to address concerns relating to staff punctuality. She had recruited more care workers, administrators and had restructured the management. There was a clear management structure in place, which provided clear lines of accountability. This comprised of the registered manager, operations manager, care coordinator, a field supervisor and an administrator. Care workers told us they understood their roles and responsibilities.

The registered manager had a sense of responsibility. She had ensured that regular audits were carried out. A range of quality assurance processes such as surveys, audits, accidents and incidents and spot checks had been used continuously to drive improvement. As noted, these improvements had ranged from staff recruitment, management restructuring, and staff punctuality.

The service promoted an open culture by encouraging staff and people to raise any issues of concern. Regular staff meetings took place and staff were free to express their views. We looked at a sample of staff meeting minutes and saw that they covered numerous topics relevant to the care of people. We saw from

the minutes that staff could make suggestions for improvement and that these were acted on.