Aspire Care Services Ltd

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This comprehensive inspection took place on 30 May and 5 June 2018 and was announced.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults. CQC only inspects the service being 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. At the time of the inspection the service were providing personal care to four people.

This was the provider's first inspection since their registration

The service did not have a registered manager in place. At the time of the inspection the manager had submitted an application to the Commission to become registered. 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.

Although people's medicines were administered as intended by the prescribing G.P, on the first day of the inspection we identified medicines administration records did not always contain sufficient information, in line with good practice. We shared our concerns with the manager, who on the second day of the inspection had developed a detailed medicine recording chart to remedy this issue. We were satisfied with the manager's response.

The provider had developed risk management plans that were detailed and reviewed regularly, however guidance for staff on managing identified risks was not always clear. We raised our concerns with the manager on the first day of our inspection. On the second day of the inspection the manager had devised a clearer format enabling staff to swiftly identify guidance on mitigating those risks. We were satisfied with the manager's response.

The provider did not have robust systems and processes in place to effectively monitor the service on the first day of the inspection. Auditing processes were not in place in relation to medicines management, risk assessments and care plans. We raised our concerns with the provider and on the second day of the inspection the provider had developed processes to ensure the overall governance of the service was regularly reviewed, monitored and action taken to drive improvement.

People were protected against the risk of abuse as staff received on-going training in safeguarding and were aware of the provider's procedure in responding, reporting and escalating suspected abuse. Staff were aware of the provider's safeguarding policy and were confident concerns raised would be acted upon in a timely manner.

People received care and support from sufficient numbers of familiar staff. The provider's employment checks ensured staff were safe to work at the service, prior to delivering care. Staff received on-going training to effectively meet people's needs. Training included, safeguarding, medicines management, Mental Capacity Act 2005 and moving and handling.

Staff were supported to reflect on their working practices through regular supervisions. Staff were also received support and guidance from the management team who were regularly available in the main office or on the phone at any time.

Staff and the manager were aware of their roles and responsibilities in line with the Mental Capacity Act 2005. People's consent to care and treatment was sought prior to care being delivered. People had their privacy respected and their dignity maintained and people and their relatives described staff as respectful, caring and excellent.

People were protected against the risk of cross contamination because the provider had systems and processes in place to manage infection control. Where agreed in people's care packages, people received support from staff members to make and prepare meals that met their dietary needs and requirements.

People received personalised care that was regularly reviewed to reflect their changing needs. Care plans were detailed and gave staff clear guidance on how to meet people's needs in line with their preferences.

Where agreed in their care plans, people were supported to participate in activities both in house and in the local community. People were encouraged to raise their concerns and complaints. The provider had a complaints policy in place.

Relatives and healthcare professionals spoke positively about the service and found the management team responsive to their needs.

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. People were protected against the risk of harm and abuse as staff received on-going training in safeguarding and were aware of the appropriate response to suspected abuse.

People were protected against the risk of avoidable harm, as the provider had developed risk management plans that identified the risk and gave staff guidance on how to mitigate those risks.

People's medicines were managed safely.

Sufficient numbers of suitable staff were deployed to keep people safe. Staff underwent robust pre-employment checks to check their suitability for the role, prior to commencing employment.

People were protected against the risk of cross contamination, because the provider had clear infection control policies in place.

Is the service effective?

Good

The service was effective. Staff received regular training to enhance their knowledge and skills to effectively meet people's needs.

People received care and support from staff that reflected on their working practices through regular supervisions and support from the management team.

The manager and staff knew their responsibilities in line with the Mental Capacity Act 2005 legislation. People's consent to care and treatment was sought and respected.

Where agreed in people's care package, people were supported to access sufficient amounts of food and drink that met their dietary needs and requirements.

Is the service caring?

Good

The service was caring. People and their relatives were satisfied

with the care and support they received.

People were treated with dignity, respect and had their human rights encouraged and promoted.

People received the level of support they needed and had their independence encouraged wherever possible.

People's personal information was treated sensitively and confidentially. The provider had systems and processes in place to ensure only those with authorisation had access to confidential documentation.

Is the service responsive?

Good

The service was responsive. People received person centred care and support. Care plans were devised with people, their relatives and healthcare professionals' input.

Where agreed in people's care packages, people were supported to access the local community.

The provider had a complaints procedure in place which was shared with people and their relatives.

Is the service well-led?

Requires Improvement

The service was not always as well-led as it could be. The provider did not carry out regular audits of the service. On the first day of the inspection, there were no systems and processes in place to monitor and oversee the service. On the second day of the inspection the manager had implemented audits.

People's views were sought through quality assurance questionnaires, spot checks and regular calls.

The manager actively encouraged working in partnership with other healthcare professionals to drive improvements.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 May and 5 June 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection was carried out by one inspector.

Prior to the inspection we reviewed the information we held about the service, this included statutory notifications and the Provider Information Return (PIR). A PIR is a document the provider sends us, to share key information on how and what the service does well and any areas of improvement they plan to make.

During the inspection we spoke with one staff member, the manager and the director. We contacted two people and two relatives to gather their views of the service. We also looked at four care plans, four staff files, the provider's policies and procedures, staff training, medicines administration records and other records relating to the management of the service.

After the inspection we contacted two healthcare professionals to gather their views of the service.

Good

Is the service safe?

Our findings

People were protected against the risk of avoidable harm, as the provider had risk management plans in place to keep people safe. One staff member told us, "The purpose of a risk assessment is the safety of the client. You need to guide the client through the day avoiding any risks." A healthcare professional said, "The service has done a risk assessment and the coordinator has contacted me to make an appointment and undertake a review." Risk management plans were comprehensive and detailed the identified risk, what impact this may have on people and how to mitigate the risk. Although the risk assessments were comprehensive, due to the volume of information they contained, it was not always clear what steps staff should take to mitigate the risks. We shared our concerns with the manager on the first day of the inspection. On the second day the manager had devised a new format which enabled staff to clearly identify the steps to take when faced with identified risks. We were satisfied with the manager's response.

People received their medicines as the prescribing physician intended. Staff were aware of the correct procedure in administering medicines, what to do if someone declined to take their medicine and how to report any errors. Staffing records confirmed staff had received medicines management training. Although staff recorded when medicines had been administered, staff did not specifically record what these medicines were. Medicine administration records (MARs) documented the person receiving the medicine, who had administered the medicine and that the medicine administered had come from the blister packet. Care plans did not clearly record what medicines were contained in the blister packs. We shared our concerns with the manager and director on the first day of the inspection. On the second day of the inspection the manager had implemented a revised MARs which clearly detailed the medicine to be administered, dose, route and time, it also included details of what the medicines looked like, to ensure the correct medicine was being administered at the correct time. We were satisfied with the provider's response to our concerns.

Staff were aware of how to identify, record, respond and escalate suspected abuse. One staff member told us, "Safeguarding is about protecting my client, it's my job to look out for [person]. If there was a safeguarding issue, I would listen to what [person] had to say, inform them I would tell the office and record it. I'd contact the director and let him know." Staff received training in safeguarding and confirmed they were confident any concerns they raised would be addressed in a timely manner, however would whistleblow should this not be the case. At the time of the inspection there were no on-going safeguarding referrals.

At the time of the inspection there had been no recorded incidents or accidents. We spoke with the manager who was aware of the appropriate steps to follow in ensuring all incidents, accidents and near misses were investigated, shared with appropriate healthcare professionals and reviewed to minimise the risk of repeat occurrences.

The provider had systems and processes in place to ensure there were adequate numbers of suitable staff to keep people safe. One relative said, "The staff are familiar which is so good." Staff spoke positively about staffing levels telling us there were sufficient numbers of staff deployed. Rotas and timesheets confirmed

staffing levels were adequate to meet people's needs and where shortages were identified senior staff covered. The provider also ensured staff underwent robust employment checks prior to successful employment. Staff files contained satisfactory references, employment history, photographic identification and a current Disclosure and Barring Services (DBS) check. A DBS is a criminal records check employers undertake to make safer recruitment decisions.

Systems and processes in place ensured people were protected against the risk of cross contamination. One staff member told us, "I've had infection control training and it was good. We do get gloves, aprons and yellow bags. If I run out of equipment the office will deliver the items to the client's house within 24 hours, so I make sure I report before the items have run out." Staff were aware of the correct action to take if they had concerns with infection control management. The provider had an effective infection control policy in place which staff were familiar with.

Good

Is the service effective?

Our findings

People received effective care and support from staff that were well trained, knowledgeable and skilled in their roles. A relative said, "[Staff] are experienced and I think they're well trained." Staff were positive about the level of training provided by the service and felt this equipped them to carry out their role to the best of their abilities. For example, one staff member told us, "I think the training's really good and we do get a lot of help if we don't understand something. The last training I did was food hygiene. If I requested more training, they [the service] would provide it." Training records confirmed staff received training in, for example, safeguarding, first aid, moving and handling, medicines management and Mental Capacity Act 2005.

Upon successful employment staff received an induction to familiarise themselves with the service, people and their roles and responsibilities. One staff member told us, "I had an induction, received training and was introduced to the clients. I shadowed a care coordinator and felt very comfortable. The care coordinator was thorough in what she showed me." The induction covered communication, care plans, confidentiality, medicines, emergencies and reporting and recording. Staff were required to shadow experienced staff and be observed satisfactorily completing set objectives prior to working without direct support.

The provider had systems and processes in place to ensure staff received on-going support in their roles and opportunities to reflect on their working practices. Supervisions were carried out regularly and topics of conversation included, safeguarding, rotas, concerns and worries, personal development, time keeping and team work. Through these discussions, action plans were developed with staff to ensure goals were set for the upcoming months. Where possible management ensured feedback from their clients was incorporated into the staff supervisions.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the provider was working within the principles of the MCA. Staff received training in MCA and had sufficient knowledge in their roles and responsibilities with legislation. People's consent to care and treatment was sought and their decisions respected. One relative said, "Whenever the staff come, they're great [relative] and explain what they want to do. [Relative] will use gestures to give consent. If [relative] says no, they will give him time and will then try to ask again. They [staff members] are respectful." A healthcare professional said, "Oh I think [staff member] would [seek consent] and they speak to my client. My client is someone that would be able to give consent and say so quite clearly." Staff were aware of the importance of seeking consent and told us, "I ask for [person's] consent and if [people] do not give consent I would respect their wishes. But I would let the office know."

Where agreed in people's care packages, staff would help them to prepare meals that met their dietary requirements and preferences. One staff member said, "I do cook and prepare meals for [person]." Staff

received training in food hygiene and were aware of how to ensure people with specific dietary requirements were catered for in line with their care plans.

Good

Is the service caring?

Our findings

A relative described staff saying, "They are really good to be honest. All the family are so happy with the service." A healthcare professional said, "My client hasn't complained much about [staff member] which tells me they're getting along okay." Staff spoke about people they supported respectfully and with kindness. For example, one staff member said, "I've learnt so much from [person they supported], he gives staff advice and I really enjoy working with him."

Staff were aware of the importance of treating people with respect and maintaining their dignity. Staff were able to give examples of where they maintained people's dignity, for example ensuring the curtains and windows were shut when delivering personal care. The manager of Aspire Care Services had undertaken the role of 'Dignity Champion' and guidance on respecting and maintaining people's dignity was covered during staff inductions.

People were encouraged to express their views and had their views respected. One relative said, "The office contact me every few months or visit and ask if we are having any problems or if things are going well. The carer always asks me if there's anything else they can do for my [relative]." Three monthly care plan reviews involving people, their relatives and healthcare professionals were undertaken and their views were incorporated into the care plan and delivery of care.

People were treated equally and diversity was celebrated and championed. Staff were aware of the importance of ensuring people's cultural needs and faiths were respected and incorporated into the delivery of care. One relative told us, "[Office] have sent staff members that speak the same first language as my [relative]." One staff member said, "[Person] fasted during Easter, I prepared foods for when he was fasting. I checked to make sure he had eaten but I also changed my shifts around to arrive earlier so that I could provide meals in line with him fasting." People were supported to attend places of worship where agreed in their care package.

People's independence was encouraged and regularly assessed through care plans and daily observations. Staff were aware of the importance of supporting people to maintain their independence wherever possible. Care plans detailed what level of support people required to achieve aspects of their personal care and this was regularly reviewed to ensure support provided was in line with people's needs.

People's confidentiality was maintained and protected. Confidential records were kept securely, with only authorised personnel having access to the documentation, which was kept in a locked cabinet in a locked office. Staff received guidance in confidentiality through the provider's induction programme.

Good

Is the service responsive?

Our findings

People received care and support that was tailored to their specific needs and requirements. A healthcare professional told us, "There may be occasions when the [person] changes what they want the carer to do and the carer does it. I've been involved in the care plan to a degree." Care plans were devised in conjunction with the service needs assessment. The service needs assessment is an assessment the service carry out to ascertain if they can meet people's needs prior to delivering care. Once completed this is reviewed by management and a care plan is created to reflect people's needs, level of support required and wishes in relation to the care and support they'd like to receive.

Care plans were reviewed regularly and changes implemented shared with staff members to ensure the care and support delivered was responsive to people's current needs. A staff member told us, "The care plans are there so that as care support workers, we can understand what [people] need. We can understand the way they live and can support them to live that way." Care plans covered, for example, health and wellbeing, medical needs, communication and preferences. We reviewed the care plans in place and found these to be detailed and gave staff clear and current guidance on how to meet people's individual needs.

A relative spoke positively about staff delivering care and support at the agreed times. One relative told us, "The staff always turn up on time. There are lots of road works at the moment and they [staff] will tell me if they're running late." Staff were aware of the importance of arriving at visits at the correct time, and confirmed they would contact the office and the person should they be running late. At the time of the inspection the provider was not using an electronic monitoring system to monitor late or missed visits. We spoke with the provider who was currently sourcing an electronic monitoring system and told us they allocated staff who met people's needs, but also lived in close proximity to the person they would be supporting, thus reducing the likelihood of late visits.

Where agreed in people's individual care packages, people were supported to participate in activities of choice. A staff member told us, "I take [person] to the bank and the barbers, I do try to encourage [person] to leave the house but they prefer to stay at home." We spoke with the manager who said, "We will be meeting with [the local authority] to agree a care package to provide specific activities." Records confirmed staff supported people into the local community, to support with shopping.

Upon using the service, people were provided with a copy of the provider's complaints procedure, which detailed what to expect, who they could contact and how this would be investigated. Staff were aware of the correct procedure in responding to and reporting any complaints. At the time of the inspection there had been no official complaints received in the last 12 months.

People's wishes with regards to their end of life care were not clearly documented. The service did have documentation to record people's wishes, however these were not always completed. We raised our concerns with the manager on the first day of the inspection. On the second day of the inspection, the provider showed us an updated end of life plan for people, which had been discussed with people. The document included, for example, 'what would be important to you as you approach the end of your life', 'do

you have any specific wishes' and 'is there anything that may comfort you'. The provider said, "People do not always wish to discuss this as they find it distressing. Relatives will be dealing with matters relating to end of life care."

Requires Improvement

Is the service well-led?

Our findings

On the first day of the inspection the service did not have robust systems and processes in place to monitor the service. We identified, medicines audits, staff files, risk management plans, staff training and other records relating to the overall management of the service, were not regularly monitored to identify areas for improvement. We raised our concerns with both the manager and director who said the previous registered manager was responsible for the oversight of the service.

On the second day of the inspection the director told us, "Since [the first day of inspection] we've now audited what we think we needed to do. This includes, care plans, risk assessments, medicines etc. We now have audits in place to include staff records." We reviewed the auditing processes now in place and found these included, for example, risk assessments, care plans, staff records, medicines and daily logs. Audits were scheduled to occur weekly, monthly and three monthly. We were satisfied with the director's response.

The provider had not always ensured that risk assessment, MAR and people's end of life care wishes were fully documented, as referred to earlier in this report. By the second day of inspection the provider had taken steps to make improvements in these areas. We will review this at their next inspection to ensure the changes they introduced have been sustained.

People spoke positively about the management of the service. One person told us, "I'm satisfied so far." A healthcare professional said, "I find the management responsive and on the ball." A staff member told us, "I can contact the care coordinator and if they aren't available I would contact the director. [Director] is always available on the phone and will take my calls. He's very supportive and I do feel I can talk to him." During the inspection we observed staff speaking with the manager and the director, there was a relaxed atmosphere and people looked at ease seeking guidance and advice.

Staff were aware of the provider's values and confirmed these were echoed throughout the organisation. One staff member told us, "The company aims to give the best they can and to give the best care to people and to staff as possible. They [the service] do value and care about us [staff members], they do value us quite a lot."

Although the service had not submitted any statutory notifications within the last 12 months, the manager and director were aware of what notifications they were required to submit and when.

People were encouraged to share their views of the service through quality assurance questionnaires. Questionnaires were completed by people and asked people if, their needs were being met, whether care was provided in a way and at a time that suited them, if staff were consistent, treated them with respect and if they were aware of the complaints procedure. We reviewed the completed questionnaires and found responses were positive. Despite positive responses being received, it was unclear as to when questionnaires were undertaken and their frequency. We raised this with the director who told us, "The quality assurance questionnaires have now been redone and updated to include the dates." Records confirmed what the director told us.

Both the manager and the director were keen to promote and enhance partnership working to drive improvements. The manager told us, "We refer people to the local community centre if people require further support, that we are unable to deliver in line with people's care package. We communicate a lot with the local authority and district nurses." Records confirmed guidance and support provided by healthcare professionals was implemented into the delivery of care.