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Wilaade Care Service

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 announced inspection took place on 12 and 13 November 2018. Wilaade Care Service was first registered with the Care Quality Commission on 22 November 2017; this was the first comprehensive inspection of the service.

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 adults. At the time of inspection, the provider was supporting 19 people with personal care.

Not everyone using Wilaade Care Service receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

The registered provider was also the manager of the service, therefore the service is not required to have a registered manager in post. Registered providers and registered managers are 'registered persons' and as such have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider did not have all appropriate measures in place to assure themselves of the quality and safety of the service. People could not always be assured that their care visits would take place at the agreed time. Records of staff training needed to be collated to ensure the provider had sufficient oversight of staff learning and development.

Policies and procedures were not always followed; staff recruitment processes needed to be strengthened to ensure that all necessary checks and risk assessments had been completed as part of the staff selection process. The registered provider needed to ensure that staff were provided with regular formal supervision in line with their policy.

People were supported in a safe way. Staff had an understanding of abuse and the safeguarding procedures that should be followed to report abuse. All the staff we spoke with were confident that any concerns they raised would be followed up appropriately by the provider. People had risk assessments in place to cover any risks that were present within their lives, but also enabled them to be as independent as possible.

There were safe systems in place for the administration of medicines and people received their medicines as prescribed. Staff supported people in a way which prevented the spread of infection. Staff used the appropriate personal protective equipment to perform their roles safely.

Staff completed induction training where they completed mandatory training courses and were able to shadow more experienced staff.

Where needed staff supported people to have access to suitable food and drink. Staff supported people to health appointments when necessary. Health professionals were involved with people's care as and when required.

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

People were involved in their own care planning as much as they could be, and were able to contribute to the way in which they were supported. Care planning was personalised and considered people's likes and dislikes, so that staff understood their needs fully. People were in control of their care and listened to by staff.

Staff treated people with kindness, dignity and respect and spent time getting to know them and their specific needs and wishes. People told us they were happy with the way that staff spoke to them, and they provided their care in a respectful and dignified manner.

The service had a complaints procedure in place. This ensured people and their relatives were able to provide feedback about their care and to help the service make improvements where required.

At this inspection we found the service to be in breach of two regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Recruitment procedures needed to be consistently implemented to ensure the safety and suitability of staff to work in the service.

People could not be assured that their care would always be delivered at the agreed time.

Staff were clear on their roles and responsibilities to safeguard people. Risks were managed and reviewed regularly to keep people safe from harm, injury and infection.

People were supported to take their medicines safely.

Is the service effective?

Good

The service was effective.

Staff felt supported in their role and had completed the training they needed to provide effective care.

People were actively involved in decisions about their care and support needs. Staff demonstrated their understanding of the Mental Capacity Act 2005 (MCA).

People were supported to maintain their health and well-being. If people needed assistance with their meals and drinks staff provided this.

Is the service caring?

Good

The service was caring.

The staff were kind and caring and understood the importance of building good relationships with the people they supported.

Staff supported people to be independent and to make choices. People's privacy and dignity was respected.

People were provided with support and information to make decisions and choices about how their care was provided.

Is the service responsive?

Good

The service was responsive.

People had individualised care plans. Care and support was delivered in the way that people chose and preferred.

A complaints policy was in place and information available to raise concerns. People knew how to complain if they needed to.

Is the service well-led?

Requires Improvement

The service was not always well-led

Formal quality assurance systems had not been implemented appropriately which had resulted in some shortfalls in the service.

People, relatives and staff were encouraged to provide feedback about the service and this was used to drive improvement.

People's diverse needs were recognised, respected and promoted.

Wilaade Care Service

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 the 12 and 13 November 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because we needed to be sure staff would be available to meet with us. We visited the office location on the 12 November to review care records and policies and procedures and talk with the registered provider and office staff. We completed the inspection with telephone calls to people and staff on the 13 November.

The inspection team consisted of an inspector and an inspection manager.

On this occasion, we had not asked the registered provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we offered the registered provider the opportunity to share information they felt relevant with us.

We contacted commissioners and asked them for their views about the service. Commissioners are people who work to find appropriate care and support services for people. We also requested information from Healthwatch. Healthwatch is an independent consumer champion for people who use health and social care services.

We spoke with three people using the service and three people's relatives. We also spoke with the registered provider, the care co-ordinator and three members of care staff. We looked at records relating to all aspects of the service including care, staffing, and quality assurance. We also looked at four people's care records and three staff recruitment files.

Requires Improvement

Is the service safe?

Our findings

People were not protected against the risks associated with the appointment of new staff. During the inspection we identified that improvements were required to recruitment procedures, to ensure that staff were of sufficiently good character. The registered provider had not assured themselves of the suitability of staff as they had not consistently acted upon the findings of unsatisfactory Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out criminal record and barring checks on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions. Where a past criminal conviction had been identified on a staff member's DBS certificate the provider had not carried out a risk assessment to assess the individual's suitability to work with vulnerable people.

People could not be assured that staff were of sufficiently good character to work in the service as the registered provider had not consistently followed safe recruitment procedures. Staff did not have employment references from their last employer. Employment references had been requested, but there was no evidence that they had been followed up and no risk assessments were in place to mitigate the risks to people. The registered provider did not have an employment history for one member of staff. They could not be assured that the staff providing care and support to people in their own homes were fit and proper to do so. This put people supported by the service at risk of receiving care from people that were not suitable to carry out their role.

This is a breach of Regulation 19 (1) of the HSCA 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed.

People could not always be assured that staff would always attend their scheduled visits at the agreed time or that they would routinely be informed when staff were going to be late. People had mixed views about the timeliness of their care visits. Some people told us that staff did not always attend at the scheduled time and that staff occasionally seemed rushed. One person said, "Evening time is variable, I don't like the call too early, but they can come as early as 7pm which is too early for me, I prefer a later call." The person explained that when the call was too early they had to go to bed earlier than they wanted to. People also said they were not always informed of late visits. One person's relative said, "On odd occasions they are extra late, there's a tolerance of twenty minutes…I ring the agency if they're more than half an hour late… it's usually the five o'clock visit, they say it's the traffic…on the odd occasion [care co-ordinator] or staff ring, but more often I have to ring them." Another person's relative said, "Most of the time they [staff] come when we expect but they can be late." No one we spoke with had experienced a missed care visit.

We spoke with staff to check whether they felt able to attend people's visits at the correct time. Staff told us that they usually attended people's care visits at the scheduled time and that their schedule of visits allowed them time to travel from one person to the next. One member of staff said, "We have time to do everything required and there is normally a gap between visits. If I am running late I let the person know, but mostly we're on time."

We reviewed staffing planners which showed that there was travel time between the majority of visits,

however a minority were allocated back to back with no travel time between. The provider explained that this was an oversight and recognised that this would impact on the ability of staff to attend people's care calls at the time they were expected. They agreed to review staffing deployment and since the inspection have carried out supervision meetings with staff where they have discussed the importance of attending people's care visits at the agreed time.

Some people told us that they did not receive a rota, so did not know on a daily basis which staff would be providing their care. They said that they would like to know who would be visiting them. We discussed this with the registered provider who agreed to ensure people were provided with a rota.

People and relatives said they were satisfied with how staff supported people with their medicines, ensuring that staff visited at the correct time to administer the medicines and providing the assistance people needed. One person said, "They [staff] always give me my pills." People received their medicines as prescribed and we saw that staff consistently recorded when they had administered people's medicines.

Staff had been provided with training on the safe handling, recording and administration of medicines. Staff competency to administer medicines was assessed by the registered provider and staff we spoke with confirmed that the registered provider had observed them administering medicines to ensure that they were competent. However, these assessments were not recorded. We discussed the need to have a written record of the assessment to ensure consistency of practice. The registered provider recognised the need to formally record their assessments of staff competency to administer medicines and since the inspection has carried out recorded competency assessments for all staff.

People and relatives said people were cared for safely. They told us that people felt safe when staff were in their homes. One person who required a high level of support to move said, "They are very careful and make me feel safe."

We talked with the staff about safeguarding people from abuse, and they understood the correct procedures to follow. Staff told us that they had received training in safeguarding and spoke knowledgeably about the possible signs and symptoms of abuse and how they would respond to potential abuse. One member of staff said, "If I suspected abuse I would report to the manager, we were also told how to report outside the company in our training." Another member of staff said, "There is the local authority safeguarding team if you need to report anything."

People and relatives said staff protected people from risk. One person said, "The physiotherapist came out and gave me a [type of manual handling equipment], the staff are very good at using it."

People had risk assessments in place so staff knew how to support them safely. Risk assessments covered areas such as medicines, mobility, falls, skin integrity, and the person's environment. Where risks were present staff were given instructions on how to monitor these. For example, risk assessments had been undertaken to identify any risk whilst supporting people to move; appropriate controls had been put in place to reduce and manage these risks.

People were protected by the prevention and control of infection. They told us staff washed their hands and wore disposable gloves and aprons when providing personal care or applying prescribed creams. Staff were trained in infection control and understood the service's infection control policy and procedures. One member of staff said, "I've had training in infection control, hand washing is important and we wear gloves and aprons, [the provider] gives them to us."

Lessons were learnt and improvements made when things went wrong. There were processes in place to ensure that accidents and incidents were recorded and reported to the registered provider and outside agencies as necessary. We saw that near misses and accidents were discussed in staff meetings to ensure staff were aware of their responsibilities.

Good

Is the service effective?

Our findings

People's needs and choices were assessed before they received support from the service to help ensure it was suitable for them. One person, told us, "They came and talked to me and my family about what I wanted and needed." Another person's relative said, "They [registered provider] came and spoke to us, we have a care plan in the folder." Records showed that peoples' needs were assessed, including their cultural and religious requirements and preferences, so staff were aware of these as soon as they began using the service.

Staff received an induction before working alone with people. One person's relative said, "New staff always come with an experienced carer first." A member of staff told us, "When I first started I shadowed [registered provider] so they could supervise me while I was learning… I learned a lot of technical things from them." The registered provider explained that their induction was based on the Care Certificate and staff were currently working through the knowledge and skills required to complete this. The Care Certificate covers the fundamental standards expected of staff working in care.

A basic programme of mandatory training was in place; this included training for staff in safeguarding, first aid, moving and handling and food hygiene. People thought that staff were well trained and understood their needs. One person's relative said, "[Person's name] has [medical condition], the staff understand that well, they know how to talk to them, they have good knowledge." Staff spoke positively of the training they had received, one member of staff said, "The training is good, I've been trained in safeguarding, Mental Capacity Act, using different equipment, medicines, record keeping and respect and dignity." The registered provider was developing the range of training they were offering to staff to ensure that staff had the opportunity to continually develop their knowledge and skills.

Staff felt supported in their role however, they did not always have access to regular formal supervision. One member of staff told us, "I'm able to chat with [registered provider] and [care co-ordinator] but I've not had a formal supervision with them." The registered provider agreed that other than one member of staff who had received an observed spot check of their practice, no staff had received a formal supervision meeting. They recognised that staff should be provided with regular opportunities to enable them to reflect upon their practice and identify areas for development. Since the inspection they have ensured that all staff have received a supervision meeting and have provided assurances that these will take place at the intervals stated in their supervision policy.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make 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 interests and legally authorised under the MCA. Applications to deprive a person of their liberty in their own home must be made to the Court of Protection.

The registered provider was working within the principles of the MCA. The staff team had received training in the MCA and those spoken with understood their responsibilities within this. People were encouraged and supported to make decisions about their care and support on a daily basis. People told us staff gained their consent before providing them with care and support. One person said, "They [staff] do everything in the way I want them to." Another person's relative said, "They [staff] provide the care in the way we want it providing."

Staff supported some people with their meals. People had nutritional care plans in place setting out their likes and dislikes and whether any cultural or other factors affected what they ate.

Staff supported people with their healthcare needs and contacted health care professionals, for example GPs and district nurses, if they were unable to do this themselves. They monitored people's health and well-being and discussed any concerns with the person or their relative if appropriate. For example, one person told us that staff had been concerned about their health, they had discussed this with them and advised that they call their doctor. The person felt that staff had been vigilant in noticing the changes. They were pleased that staff followed this up with them after they had visited their doctor to see if there was anything they needed to be aware of.

The majority of people managed their acute health care needs and medical appointments independently or with the support of a relative. However, staff were aware of the appropriate action to take if a person became unwell and required their support to access a healthcare service. One staff member explained how they had contacted emergency services when they visited a person and found that they had fallen.

Good

Is the service caring?

Our findings

People told us staff treated them with kindness and compassion. One person said, "They are very caring… they are nice to me." People's relatives made positive comments about the care staff who visited their family member. One person's relative said, "They talk a lot to [person's name], they try to make them laugh."

Staff spoke of people they supported in a caring and compassionate way. They were able to demonstrate their knowledge of people and tell us what was important to people, their likes and dislikes and the support they required. Staff told us that they considered people's emotional needs and got to know people well. People benefitted from continuity and the relationships they had built with the staff that provided their support. One member of staff said, "I go to one client who lives alone, they need someone to talk to, it's lovely to be able to talk to them and comfort them." Another member of staff said, "I have a regular round of clients I visit, that way the clients get used to the carers."

People and relatives told us staff respected people's cultural needs and supported them to follow their beliefs and customs. People were able to choose whether they wanted male or female staff to provide their personal care and people's care assessments prompted consideration of their cultural needs.

People had access to their care plans and care notes. People, and relatives where relevant, said they had contributed to their care plans. One person's relative said, "[Care co-ordinator] has met with us and written down what [person's name] needs, [person's name] was able to be involved." When people's needs changed the provider or care co-ordinator met with them to discuss how staff would continue to meet their needs. People told us that they felt involved in all decisions related to their care and were supported to make their own choices. A member of staff told us, "It is important to respect people's decisions."

Staff respected and promoted people's privacy, dignity and independence. People gave us examples of how staff provided them with dignified care and support. One person's relative described how staff supported their family member with personal care, saying, "They always put a towel over [person's name] to protect their modesty."

Staff understood people's right to confidentiality. One member of staff told us, "I would not discuss any client with another client, or discuss clients with other people who don't need to know."

People's support was provided in a way that encouraged their independence. People's care plans reminded staff of the need to encourage people to be as independent as they were able to be when providing their care.

Good

Is the service responsive?

Our findings

People said they were satisfied with the care and support provided which was personalised and met their needs. One person said, "All the staff are very kind and understand my restrictions, they're very considerate." Another person referring to the main carer who provided their support said, "[Staff member's name] is absolutely wonderful, very caring and receptive to what I say."

Staff told us that they had time to get to know people and how they wanted their care provided. One member of staff said, "I have regular clients and have got to know them well, we have time to talk, so I know how they like things done."

Care plans provided guidance for staff when working with each person. They were focussed on the individual and contained information such as their life history and how they communicated their care needs. The things that were important to people were clearly identified so staff could support them to make decisions about what they wanted to do. For example, one person's care plan recorded that they liked to go out in their wheelchair. We found clear descriptions of the support people required at each care visit and any goals that people wanted to achieve. For example, it was recorded in one person's care plan that they wanted to be more independent in relation to their personal care, medicines and food and drink.

Care plans contained the information staff needed to help ensure people's equality, diversity and human rights (EDHR) needs. Care plans reflected people's rights relating to dignity and autonomy, such as how the person chose to receive their care and support. For example, one person followed a religion, which required a particular diet; this information was recorded in their care plan. Staff demonstrated a clear understanding of people's social and cultural diversity. Staff were knowledgeable about people's beliefs, preferences, and language and other communication needs.

People had access to the information they needed in a way they could understand it. This meant the service complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. People's care plans contained information regarding their communication needs and the impact of any disability or sensory loss on these. At the time of inspection no one required information to be provided in an alternative format. However, people's communication needs were considered as part of their pre-assessment and the provider told us information would be provided in an appropriate format if needed.

People and relatives told us they felt able to make a complaint if necessary and said they would speak to the staff in the office or with their carer. One person's relative said, "We have no complaints at all, they are very helpful, I would talk to [registered provider] or [care co-ordinator] if I did." We saw that there was a clear complaints policy and procedure in place. During the inspection one person raised a concern with us about a member of staff, which we fed back to the provider. The provider followed their complaints process, investigated the person's complaint and provided them with an appropriate outcome.

At the time of the inspection, no people using the service were receiving end of life care. The provider understood the importance of providing good end of life care to people and was planning to access end of life training for staff as part of their mandatory training.

Requires Improvement

Is the service well-led?

Our findings

Improvements were required to the systems in place to ensure effective governance of the service. The registered provider was actively involved in the service and monitored the quality and safety of the care provided as they worked alongside staff. However, as the service had grown there was a need to develop more formal quality assurance processes to ensure that the registered provider maintained sufficient oversight. These had not been implemented by the registered provider.

The registered provider's quality assurance process had not enabled them to ensure that all people received a consistent service. They had not ensured that people received a consistently punctual service, they had also not ensured that people were always informed if staff were going to be late.

There were policies and procedures in place which covered all aspects relevant to operating a personal care service; these included safeguarding and complaint procedures. However, not all policies and procedures had been followed, for example recruitment procedures and staff supervision procedures. The registered provider needed to ensure that the policies in place were being followed in practice.

Staff files contained individual certificates for training that they had attended. The registered provider had not developed an overview of all staff training and there was no training plan or training matrix in place. This made it difficult for the provider to monitor staff training and ensure that staff development was planned for in a consistent way.

The registered provider and care co-ordinator were working a high number of hours providing people's direct care. This had resulted in a lack of systematic management and oversight of some areas of the service.

This is a breach of Regulation 17 (1) of the HSCA 2008 (Regulated Activities) Regulations 2014, Good governance.

We discussed our concerns with the registered provider, who agreed that the number of hours they had been deployed providing people's care had impacted on their ability to monitor the governance of the service as it grew. They stated that they would not be taking on any new care provision until they had sufficient staff to meet the care visits required. This would enable them to concentrate on improving the quality and safety of the service.

Quality monitoring systems were effectively used to monitor and improve some areas of the service people received. We saw that audits were carried out on the call logs completed by staff and medicines. Any actions required in response to these audits had been taken.

People and their relatives were asked for their feedback about the service. The registered provider had carried out surveys of people who used the service. We saw that people's feedback was mainly positive and that questionnaires completed by people had been analysed and action taken in response to comments

made.

Staff said that the registered provider and care co-ordinator were approachable and committed to engaging with staff. One member of staff said "[registered provider] calls me at the end of every week to see how things are going, they're very supportive and I've learned a lot…I've worked in other larger homecare organisations and I've learned a lot more here and feel more valued." Another member of staff said, "They are a good company to work for, they share their experience and want staff to speak their mind, they are always very easy to get hold of, very supportive."

Regular staff meetings took place to inform staff of any changes and to provide a forum for staff to contribute their views on how the service was being run. We saw staff meeting minutes that demonstrated a positive inclusive culture, with discussions about health and safety, medicines management and communication.

We saw that the service was transparent and open to all stakeholders and agencies. The service worked in partnership with other agencies in an open, honest and transparent way. The provider shared information as appropriate with health and social care professionals when necessary; for example, social care professionals involved in commissioning care on behalf of people.

The provider was aware of the requirement to submit notifications to the Care Quality Commission (CQC) of any accidents, serious incidents and safeguarding allegations. A notification is information about important events that the service is required to send us by law.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have sufficient arrangements in place to monitor the quality and safety of the care and support provided.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures needed to be consistently implemented to ensure the safety and suitability of staff to work in the service.