Ark Home Healthcare Limited

Ark Home Healthcare Waterloo

Inspection report

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10 November 2016

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 8 and 10 November 2016 and was announced.

Ark Home Healthcare - Waterloo is a domiciliary care agency delivering care and support to people in 10 London Boroughs. At the time of the inspection the service was providing support to 199 people.

The service did not have a registered manager at the time of the inspection. 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.

At this inspection we identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to insufficient staff being deployed to safely deliver planned care to people. CQC is considering the action we will take.

Some people had experienced missed and late care visits and expressed anxiety that experience may be repeated. Staff were knowledgeable about the provider's safeguarding procedures, had received safeguarding training and knew what actions to take if they suspected abuse. People's risks of avoidable harm were reduced because staff undertook risk assessments to identify and mitigate them. People received their medicines in line with the prescriber's instructions and with the amount of support identified in their assessments.

Staff supporting people were trained and supervised by line managers. People consented to the care staff provided. Staff supported people to meet their nutritional needs and with timely access to healthcare services.

People's needs were assessed and they were involved in their care plans. However, people did not always receive support at the time of day they wanted. The provider regularly sought feedback from people and their relatives. People lacked confidence in the provider's complaints procedure.

We have made a recommendation about the management of complaints.

People, relatives and staff expressed dissatisfaction with the quality of communication with office staff during office hours and during on-call periods, reporting that calls were often not answered or returned.

We have recommended that the service seek advice and support for the office based team on telephone calls management and communication with people and staff.

The service did not have a registered manager but the process of registering with CQC had been started at

the time of the inspection. The service conducted quality audits and worked in partnership with professionals from health and social care agencies. The service provided staff with mobile phones and used software to gather staff views and provide information updates.

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 safe. People were at risk of late and missed care visits.

People did not always feel safe because they were worried about missed care visits and were not always notified about changes to their care staff.

Staff received training in safeguarding and knew the actions they needed to take to keep people safe.

People's risks were assessed and plans made to mitigate them.

People's medicines were safely managed and audited.

Is the service effective?

Good

The service was effective. People received support from trained and supervised care staff.

People gave consent to the care they received.

People had enough to eat and drink.

Staff supported people to engage with healthcare professionals as needed.

Is the service caring?

Good

The service was caring. People and their relatives told us that their regular staff were kind and caring.

People's privacy and dignity were supported.

Staff promoted people's independence.

Is the service responsive?

Requires Improvement

The service was not responsive. People did not always receive care at the times they wanted and some people did not feel confident about complaining.

People had their needs assessed and were involved in the development of care plans to meet their needs.

People were encouraged to provide feedback about the service they received and the provider acted upon it.

Is the service well-led?

Requires Improvement

The service was not well led. People, relatives and staff told us that communication with office based staff and out of hours managers was not effective.

The service did not have a registered manager in post.

The provider undertook a range of audits to measure and improve the quality of service delivery to people.

Staff were supported by the provider through the use of communication technology.

The service worked in collaboration with health and social care professionals and other providers.

Ark Home Healthcare Waterloo

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 unannounced inspection took place on 8 and 10 November 2016. It was undertaken by one inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The provider was given 48 hours' advance notice because the location provides a domiciliary care service and we needed to ensure the registered manager and staff were available. This meant the provider and staff knew we would be visiting the agency's office before we arrived.

Prior to the inspection we contacted six commissioners and we reviewed the information we held about Ark Home Healthcare - Waterloo including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We used this information in the planning of the inspection.

During the inspection we spoke with 24 people and 13 five relatives. We spoke with seven staff, the branch manager and regional operations director. We reviewed 12 people's care records, risk assessments and medicines administration records. We looked at documents relating to staff and management. We reviewed 15 staff files which included pre-employment checks, training records and supervision notes. We read the provider's quality assurance information and audits. We looked at complaints and compliments from people and their relatives.

Following the inspection we contacted health and social care professionals to gather their views about the service people were receiving.

Requires Improvement

Is the service safe?

Our findings

People were at risk of missed care visits. A third of the people we spoke with told us they experienced occasions when staff failed to arrive at their home to deliver care and support. One person told us how they had experienced several missed calls and had to enlist the help of a neighbour when care staff did not arrive. Another person told us that staff had missed two care visits in a two week period. A third person told us, "Last Saturday nobody came in the evening, I had to call the office and they didn't have anyone so [my relative's partner] had to come round and put me to bed." A fourth person told us, "Once [staff] didn't turn up at all… I'm afraid that will happen again." Whilst records showed a number of missed care visits we also found missed care visits which the provider had not been aware of. We directed the branch manager to raise safeguarding alerts with three local authority safeguarding teams in relation to these.

People did not always receive their care visits as planned. The provider used electronic call monitoring systems to ensure staff arrived at people's homes to deliver care. One electronic monitoring system required staff to call a freephone PIN number from people's landlines to confirm their arrival in people's homes. Another system used a GPS tracking application in the mobile phone handsets provided to care staff to enable office staff to confirm the arrival of staff at people's homes. However, people, relatives and staff told us that staff were often late for care visits. One person told us, "Ark staff don't understand the need to get to work on time." Another person told us, "I can't really rely on them, it's all a bit mixed up." A third person told us, "They [staff] don't stick to the agreed time." A member of staff told us, "Sometimes [care visits] are too far apart to get from one to the other on time. Sometimes the traffic is bad. But we don't have people's phone numbers. We have to phone the office. If they don't answer or pass on the message that you're running late people get really annoyed firstly because we're late and secondly they are worried we're not coming." We found people were at risk of and in some cases had experienced missed and late care visits due to insufficient staffing.

This is a breach of regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were protected because staff had safeguarding knowledge. Staff we spoke with were able to recognise signs of a person being abused and knew the actions they needed to take and when to take them. One member of staff told us, "I would contact the office and the manager immediately if I thought abuse had happened." Another member of staff said, "I'd call the office and they would swing into action, telling social services and even the police if needed."

People's safety was enhanced because staff knew the actions to take if the provider did not address concerns about abuse. All of the staff we spoke with understood the provider's whistle blowing procedures. Whistleblowing is a term used when staff alert an outside agency to their concerns about the practice of care staff or managers. One member of staff told us, "If concerns I raised weren't dealt with properly I would contact social services or the CQC."

People's risks of avoidable harm were reduced because staff assessed risks and plans were written to manage them. People at risk of falls had their mobility needs assessed and referrals were made to

healthcare professionals. Guidelines were included in care records along with people's views. For example, one person's care records stated, "I can only bear my weight for not more than three minutes." Whilst another person was noted as saying, "I walk slow when I'm indoors using my Zimmer fame." Where people required assistance to transfer and reposition this was detailed in care records.

People were supported to maintain skin integrity. People at risk of pressure ulcers had their risks assessed. Care records guided staff as to the steps to be taken to protect areas of peoples' skin at risk of pressure sores. For example, people were supported to reposition regularly and staff applied barrier creams. Care records directed staff to inform healthcare professionals if they observed any discolouration on peoples' skin. A member of staff told us, "I help people into the positions that are in their care plans and I encourage them not to be static."

People were supported by staff recruited through safe procedures. Prospective staff submitted application forms, were interviewed and had two references taken up if their interviews were successful. Proof of identity and address as well as a check of criminal records were undertaken before staff were employed to deliver care and support to people. This meant that staff were suitable to support people in their homes.

People were supported to take their medicines in line with the prescriber's instructions. The support people required to take their medicines was stated in care records. For example, one person was supported with verbal prompting in the form of a reminder whilst another person required staff to open their blister packed medicine. One member of staff told us, "It's important to refer to the care plan when dealing with people's medicine as it tells you what support to give." Staff maintained accurate Medicines Administration Record (MAR) sheets for people. MAR sheets noted the medicines people were prescribed, when to take them and at what dose. Staff recorded whether people had taken their medicines or the reasons why they had not, including refusal and health appointments. People's allergies to medicine were noted prominently on MAR sheets and care records noted the known symptoms of peoples' allergic reactions. For example, swelling and rashes and the actions staff should take. This meant people took their medicine safely.

Staff followed procedures to keep people safe in their homes. Staff wore uniforms and carried photographic identity cards. The means of entry to people's homes was stated in care records. For example, some people used entry phones and others used key safes. However, several people told us they did not always feel safe because they were not informed by office staff that their usual care staff had changed. One person told us that because of their visual impairment they became worried when someone other than their usual care staff announced their arrival in the person's home without prior notice from the office staff. Another person told us, "I want to know who I am opening the door to especially in the morning when I am a bit sleepy." Care records noted the location of emergency shut off points in people's homes. For example, records stated where water, gas and electricity. This meant staff had the information they required to protect people in an emergency.

People were protected from infection by the hygiene practices of staff. People received personal care from staff who wore personal protective equipment. Staff told us they regularly collected gloves and aprons from the office for use during care visits. With people's consent staff checked people's fridges for out of date food which they removed and discarded. This meant people were protected against the risk of food poisoning.

Good

Is the service effective?

Our findings

People and their relatives expressed mixed views as to how well trained, knowledgeable and skilled they thought care staff were. Some people were positive. For example, one person told us, "[Staff] seem to know what they're doing and I'm happy with it." Another person described their care staff as "magnificent." However, some people's comments were negative. For example, one person told us, "[Staff] have minimal training, in the beginning they sent someone who didn't know how to manage a catheter." Another person said the effectiveness of staff was "hit and miss [when] different carers come." We spoke with people's relatives. One relative told us, "I'm always telling them what to do, I'd be better doing it myself." Another relative said, "[The member of staff] was very nice but he didn't know what he was doing." We spoke with staff who told us they received "occasional" training but would like more. One member of staff told us, "I'd like to expand my skills set and learn things like mental health and autism."

We reviewed the provider's training matrix. This showed all staff had been provided with training in the mandatory areas of moving and positioning; medicine, health, safety wellbeing and first aid and safeguarding. Whilst the training matrix showed that 24% of staff were overdue for refresher training in all four mandatory areas, the service was able to track and schedule staff training and had recruited two training staff to deliver it. This meant people received support from trained staff.

People were supported by staff who received an induction. The service delivered a four day classroom based induction course to new staff. Subjects covered included mandatory training and the provider's expectations of staff. A member of staff told us, "For me unquestionably the most important part of my induction was the moving and handling training. I learnt how to use hoists, slide sheets, rotator stands and help people transfer." Following induction training staff were supported to shadow experienced colleagues in order to meet people and observe good practice. One member of staff told us, "I shadowed for two days and I requested a few more until I felt confident." This meant people were supported by staff who were sufficiently competent and confident to meet their needs.

People were supported by supervised staff. Members of staff had one to one meetings with their line managers to discuss people's changing needs. One member of staff told us, "I have supervision with my team leader. These are really helpful. We talk about my visits and if anything has changed, like one time a person was getting unsteady on their feet. We did the referrals and a physiotherapist gave us some exercises to do and the problem was sorted without a second staff or even mobility aids." Team leaders and care coordinators also undertook direct observation of staff whilst they delivered support to people and evaluated their performance.

People gave consent to the care and support they received. People were involved in the assessment of their needs and the development of their care plans. Care records were signed by people to confirm their agreement with support plans. People were treated in accordance with the Mental Capacity Act 2005 (MCA).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 interests and legally authorised under the MCA.

People were given the support they required to eat and drink sufficiently. People who required support to eat and drink safely had their needs assessed and care records guided staff as to the actions they should take. For example, some people required their foods to be pureed to prevent choking, whilst others required their drinks to be thickened to prevent aspiration. People who needed support to be positioned correctly to eat and drink had clear descriptions of their positions in care records. This meant people were supported to eat and drink safely.

Care records noted people's preferences for meals. One person's care records stated,
"I like mashed food and don't like eating dairy products." Another person's care records quoted a person as saying, "I don't have food allergies but I'm very selective." Where people were vegetarians it was reflected in care records. A member of staff told us, "Mostly we don't cook for people. Meals on wheels deliver or relatives make it. We just plate it and support people how the care plan tells us to."

People had access to healthcare services as their needs required. Staff supported people to refer to healthcare services via their GPs and social workers. Care records noted the professionals involved in people's care and treatment. For example, staff supported people to receive input from chiropodists, physiotherapists, district nurses and GPs. This meant people had timely access to health resources.

Good

Is the service caring?

Our findings

People told us their regular care staff were kind and caring. One person told us, "[Staff were nice people, kind and caring." Another person described staff as "efficient kind & compassionate." However, people told us this was not always the case with staff who were not their regular carers. One person told us, "Yes, the regular staff are [caring], not always the substitute ones." Another person told us, "[The staff] were marvellous the first week and now they've changed." A third person told us, "Some of them are kind and caring but we get all different ones." Another person said, "I don't want all different people." We found that the people who were most satisfied with their staff and thought them to be caring were those supported by regular staff, with few changes to their planned rotas of care.

People were supported to develop positive relationships with the staff providing their care and support. Care records noted details of the most important relationships in people's lives and how relatives and friends could be contacted. Relatives were invited to review meetings when people chose. In circumstances where relatives met aspects of people's care needs, including personal care, medicine administration and support with meal preparation, this was stated in care records. This meant that staff knew what care and support they were responsible for providing.

People were supported to maintain their level of independence. People's needs and abilities were assessed and staff had guidance in care records on how to support people remain and increase their independence. For example, care records noted that one person required the use of a rubber place mate beneath their plate or bowl when eating to ensure it did not slide. This meant they were able to eat unassisted. Staff switched on an electronic device for another person and ensured it was within arm's reach to enable them to control the temperature of the room they were in.

People were supported with continence management in line with their preferences and needs. Care records detailed the personal care support people required. For example, one person required staff to empty their catheter during each care visit whilst another person required staff to change their incontinence pads. This meant that people were supported to maintain their hygiene and dignity.

Staff maintained people's privacy in relation to the documentation used to support them. Each of the staff we spoke with were aware of the provider's confidentiality policy and the need-to-know basis upon which information could be shared. People's care records were kept discreetly in their homes so that visitors would not see the private information. People's preferred names were recorded in their care records to ensure that staff addressed them as they wished.

Requires Improvement

Is the service responsive?

Our findings

People shared mixed views with us regarding the responsiveness of the service. Some people told us the timing of care visits were agreed with them and met their preferences. For example, one person told us, "We agreed the times [staff] would come in the morning and evening and my regular carer has been good at sticking to it." However, other people told us the service was not responsive to their needs around the times of care calls. For example, two people told us that weekend visits were too early in the morning whilst another person said, "[Staff] came at 7pm to put me to bed - that's too early but I had to be accommodating." A third person told us, "I wanted the afternoon [care visit] but they couldn't supply a carer then, only mornings." A fourth person told us they had requested later care visits so they could be supported with their medicines but the service could not accommodate this. A fifth person told us, they wanted to receive personal care at 10am at the latest so they could go to work but the provider could not meet their preference and staff regularly arrived as late as 11:30am resulting in the person being late for work." This meant people did not always receive person centred care that was responsive to their needs.

People's needs were assessed before they received a service. Information was provided by the referring local authorities and assessments were undertaken by care coordinators and the manager. People and their relatives were involved in assessments. Reassessments took place when people's needs changed and care records were updated accordingly. For example, following a review of their needs a healthcare professional determined that one person required the support of two staff to safely support their mobility needs and this was reflected in their updated care plan. This meant care plans were designed to meet people's needs.

People received support that was delivered in line with care plans. Care records provided staff with guidance on how to meet people's needs. Staff had clear instructions on meeting people's mobility needs. For example, one person's records directed staff on the use of their ceiling tracking hoists. Whilst another person's care records provided guidance to staff on how to support them to use their stair lift. This meant staff had guidance on how to deliver care.

Staff maintained daily records. Staff entries into daily care records included notes related to people's well-being and how their needs were supported during the care visit. For example, "Skin integrity intact and lubricated." Changes to people's needs were noted in daily records to ensure all staff had accurate and up-to-date information.

When stated in care plans people were supported to participate in activities. For example, care records showed some people were supported to shop and go to the park. Care records stated people's hobbies. These were personalised and included, crosswords, gardening and watching documentaries. This meant people discussed their preferences and interests and planned activities with staff.

The provider sought feedback from people. The provider undertook frequent surveys to obtain people's views regarding their experience of care and produced action plans in response. Action plans were reviewed to ensure tasks were completed. Most people we spoke with and their relatives knew how to complain. However, people we spoke with who had previously made a complaint expressed a lack of confidence in the

process. One person told us they had complained about not being told if there was a substitute carer visiting them and about missed appointments, but had not received a response from the service. Another person said, "I don't want to complain anymore because they'll always make an excuse." Whilst a third person told us they had "complained about mistakes made by carers and missed appointments. Things only improved when I threatened to get Social Services involved."

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

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We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives shared mixed views with us about their communication with office based staff. One person said, "I have a named person in the office so no problem contacting them." A second person told us, "They [office staff] will help if they have sufficient staff available." However, another person told us, "I do wish Ark would call me if there's a problem, not for me to have to call them. It's a bit of a worry when my regular carers are on holiday because I don't know if they'll turn up or be on time." For security and monitoring reasons staff did not retain people's telephone numbers. This meant care staff were dependent upon office staff to inform people of changes. One member of staff told us, "If you are running late you have to let the office know. If the office doesn't answer they can't let people know." Another member of staff said, "If I phone the office to speak to a care co-ordinator and they are not there, why can't someone else give me advice? They say they will pass on the message and someone will call me back but that's no good. I need advice now not later. Later I will be caring for a different person. Anyway, half the time you don't get a call back at all."

People and staff told us that concerns regarding communication with the office staff were most acute when the on-call system was in use. The on-call system was the out of hours arrangements for management to take calls in the evenings, overnight and at weekends. One person told us, "I don't bother with on-call anymore. They either don't answer [the phone], don't have an answer or can't access the system." Another person said, "On call is hit and miss. If it's not one of the good ones (office staff) you're stuffed." A member of staff told us, "Communication just has to improve. You get to someone's house and there's a problem, say no safe key. So you phone the on call and no-one answers. I mean what's the point of on-call if you don't answer the call?" Another member of staff told us, "The biggest problem is the lack of communication. I can never get hold of on-call at weekends."

We recommend that the service seek advice and support for the office based team on telephone calls management and communication with people and staff.

The provider used technology to support staff delivering care and support. Each member of care staff was issued with a mobile phone which contained an application developed for the service. The innovative employee phone app enabled staff to receive organisational news and updates. The provider also used the application to get staff feedback through a suggestion box and a feature entitled 'rate my day' which provided staff with the opportunity to write about their experiences. This meant the provider creatively sought ways to communicate with its remote care staff.

Team meetings were arranged according to the geographical locations in which care was delivered. We were told that team meetings were specific to Local Authority areas. For example, staff delivering care to people in the London Borough of Brent met as a team to discuss people's care and support. One member of staff told us, "We discuss people's well-being and what needs to change and improve. The cares, senior carers, team leader and care coordinator are there." However, some staff told us they did not attend team meetings. One member of staff told us "No, I don't remember us ever having a team meeting for the staff working with people in the Borough." Another member of staff said, "Meeting more often would be a good

thing." No minutes were available of team meetings taking place for care staff supporting people in the London Borough of Merton but were available for staff in other London Boroughs and for larger meetings of staff across the capital.

The service did not have a registered manager, however the branch manager was in the process of registering with CQC at the time of the inspection. Staff spoke positively about the branch manager and said they felt supported. One member of staff told us, "She's excellent. She has experience and she is supportive." Another member of staff said, "Speaking for myself I'd have to say she's been so helpful." The branch manager was experienced in delivering domiciliary care and had previously been registered with CQC as a manager for a separate provider. Staff understood their roles and the management structure within the office which included team leaders, care coordinators and the branch manager.

Staff told us their managers were open and approachable. One member of staff told us, "They are always supportive. When we need them they are there." Another staff member told us, "They never trivialise a concern." The provider arranged 'listening lunches' which enabled staff to meet informally with members of Ark Home Healthcare's senior management team including the director of operations, managing director and head of human resources. This meant people received care from staff who were supported by an open management. Another member of staff said, "We get birthday cards and a gift vouchers from the organisation, it makes you feel appreciated."

The branch manager audited the quality of care people received. Spot checks were undertaken by the team leaders and care coordinators. These took place in people's homes with the consent of people but without the prior notification of staff. Spot checks included observing staff punctuality and how they delivered care and support to people, used personal protective equipment and their compliance with the provider's uniform dress code. The manager analysed the results which were relayed back to staff during their supervision meetings. The manager also reviewed care records to ensure they were accurate and up to date. This meant the quality of service delivery and documentation were subject to continuous scrutiny to achieve improvements.

The service liaised with local resources including commissioners, social workers and healthcare professionals including GPs, district nurses and occupational therapists. The provider ensured that the Care Quality Commission was kept informed of important events within the service.