ASK4CARE LTD

ASK4CARE - Huddersfield

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 18 July 2018 and was announced. On 20 July 2018 we also contacted staff, people using the service and their relatives by telephone to gain feedback about the service. The service was first registered on 10 July 2017 and this was their first ratings inspection.

ASK4CARE- Huddersfield is a domiciliary care agency. It provides personal care to adults living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults. On the days of our inspection 36 people were receiving support.

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

People told us they felt safe with staff from ASK4CARE- Huddersfield. Staff had a good understanding of how to safeguard adults from abuse.

Staff were aware of their responsibilities if they were concerned a person was at risk of harm. Care files contained individual risk assessments to reduce risks to people's safety and welfare.

An electronic call monitoring system, to alert office based staff in the event a person's call had been missed, was in place and this was monitored.

People told us staff were usually on time and were not rushed. Two people's relatives told us their relation would prefer more consistency of care staff, although appreciated this was not always possible. Staff recruitment was safe.

A system was in place to ensure medicines were managed in a safe way for people. All medicine administration records (MARs) were routinely audited on return to the office to enable any concerns to be addressed promptly. Staff were trained and supported to ensure they were competent to administer medicines.

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. We saw evidence people had given their consent to the care and support they were receiving. For two people, who may lack the mental capacity to consent to their care plans, evidence of mental capacity assessment and best interest discussions needed to be improved.
We made a recommendation about this. The registered provider implemented this straight away.

New staff were supported in their role, which included training and shadowing a more experienced staff

member. We saw evidence staff had received regular on-going training in a variety of subjects. Staff received regular supervision and field based observations of their performance.

People received support with meals and drinks if this was part of their care plan. Staff knew how to access relevant healthcare professionals if their input was required. The service worked in partnership with other organisations and healthcare professionals to improve people's outcomes.

People told us staff were caring and supported them in a way that maintained their dignity and privacy. People were supported to be as independent as possible throughout their daily lives.

Individual needs were assessed and met through the development of personalised care plans, which considered people's equality and diversity needs and preferences.

Systems were in place to ensure complaints were encouraged, explored and responded to. People told us they knew what to do if they had any concerns or complaints about the service.

Everyone told us the service was well led. The registered manager had an effective system of governance in place to monitor and improve the quality and safety of the service.

People who used the service and their relatives were asked for their views about the service and these were acted on.

Further information is in the detailed findings below.

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 told us they felt safe with the staff who delivered their care.

There were risk assessments in place which ensured the care and environment was safe for both people who used the service and staff.

Systems of staff recruitment were safe.

Staff were trained in medicine administration.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff supported people's right to make choices and decisions. Where people may lack mental capacity to consent, records of mental capacity assessments and best interest discussions needed to improve.

Staff received regular training, spot checks, supervision and appraisals to ensure they were able to perform their role effectively.

Is the service caring?

Good

The service was caring.

People and their families told us staff were kind and caring.

Staff respected people's privacy and dignity.

People were encouraged to make choices and retain and improve their independence where possible.

Is the service responsive?

Good

The service was responsive.

Care was planned to meet people's individual needs and preferences.

People and their representatives were involved in the development and the review of their support plans.

People told us they knew how to complain and that staff were always approachable.

Is the service well-led?

Good

The service was well led.

The registered manager and the registered provider were involved in the day to day running of the organisation.

There were systems in place to regularly seek feedback from people who used the service.

Staffs performance was regularly monitored.

ASK4CARE - Huddersfield

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 18 July 2018 and was announced. We gave the service 24 hours' notice of the inspection to ensure the registered manager would be available to meet with us. The inspection was conducted by one adult social care inspector.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, feedback from the local authority safeguarding team and commissioners. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

Before the inspection, the provider completed 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. This information was used to help inform our inspection.

During our visit to the office we spent time looking at four people's care plans, we also looked at three records relating to staff recruitment and training, and various documents relating to the service's quality assurance systems. We spoke with the registered manager, the nominated individual and the care co-ordinator. Following the inspection we spoke with three care assistants on the telephone. We also spoke on the telephone with two people who used the service and four of their relatives.

Good

Is the service safe?

Our findings

People told us they felt safe with the care provided. One person said, "They always check if I have taken my tablets." One relative said, "Yes very safe. They know what they are doing with the equipment."

Staff we spoke with understood their role in protecting people from abuse and knew how to raise concerns both within their organisation and beyond, should the need arise, to ensure people's rights were protected. We saw information around the office about reporting abuse and whistleblowing. This showed the registered provider was aware of their responsibility in relation to safeguarding the people they cared for.

The registered provider had an Equality and Diversity Policy which outlined staff and management duties in ensuring people were treated equally, with respect as individuals and protected from discrimination based on the protected characteristics. This helped to keep people safe and challenge any discriminatory practice.

During this inspection we found evidence of detailed risk assessments in people's care plans. Risk assessments had been completed in relation to skin integrity, mobilisation and falls, medicines, fire safety, equipment, and infection control. We saw risk assessments were in place to support both people and staff.

Each care plan we looked at contained a home environment risk assessment detailing any risks relating to access, steps, fire safety, flooring and lighting and how the risk could be reduced. One staff member told us the registered manager completed further health and safety and equipment checks when conducting reviews with people.

An electronic call monitoring system was in place which flagged any late or missed care calls to the office and this was then acted on by the management team. People we spoke with told us staff had never missed their calls, with the exception of the very heavy snow this winter when two people told us their calls were unable to take place. This did not cause either person a significant risk. This meant an effective system was in place to reduce the risks associated with missed calls.

People and staff told us there were enough staff. One staff member said, "There are enough staff. We are never rushed and I am never late." One relative said, "They are usually on time. They have 15 minutes either side." A second relative said, "They are on time and they stay as long as needed." A third relative said, "On the whole they are on time. Maybe twice they have been early or late." One of the staff said they always tried to telephone the person to let them know if they were going to be delayed and people we spoke with confirmed this.

Contingency plans were in place in the event of staff sickness and managers were on call at all times that care was being delivered. This showed the service had plans in place to enable it to respond to unexpected changes in staff availability, so the service to people using it could be maintained.

One relative said, "They stay as long as needed. They are very prompt. They have provided us with short notice support." People we spoke with during this inspection did not raise any concerns that call times were

shorter than planned. We saw some examples of call times being shorter than planned on the electronic call monitoring system. The registered manager told us they had already identified this through the monitoring process and had taken action to ensure call times reflected people's current needs and charges were adjusted accordingly. The system also showed some calls were longer than planned and the registered manager told us this time was not charged for.

Most people told us they had fairly consistent carers and changes to the team were inevitable due to staff sickness or leave. Two relatives told us they would have preferred a more regular staff team. One relative said, "We don't always get the same people, but it doesn't affect the care." A second relative said, "We would prefer more consistency. They are trying their best."

Staff knew what to do if they were unable to gain entry to a person's property on a planned care call, or if they found a person had fallen on the floor when they arrived at a call. This showed the service had effective procedures in place in the event of an emergency situation.

Staff told us they recorded and reported all accidents and incidents and people's individual care records were updated as necessary. We saw from accident records staff had taken appropriate action to keep people safe. The registered manager showed us the action they had taken in response to accidents to prevent future risks and promote learning from accidents and incidents. This meant they were keeping an overview of the safety of the service.

We looked at three staff files and found safe recruitment practices had been followed. Appropriate Disclosure and Barring Service (DBS) checks and other recruitment checks were carried out as standard practice. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. One recently employed staff member had a DBS check in place and had evidence of satisfactory conduct in previous employment from one referee. However, the second referee had failed to respond to the follow up requests by the service and these requests had not been recorded to evidence this. The registered manager told us they would ensure this was recorded in future. They also closely monitored the staff member during induction to ensure they were suitable.

All staff had been trained to manage people's medicines safely and MARs were regularly audited for any issues or concerns. Medicines records were discussed regularly at staff meetings. Staff were initially supported with medicines administration when shadowing more experienced staff and the registered manager told us they planned annual medicines competence assessments to ensure on-going staff competence in line with National Institute for Clinical Excellence (NICE) guidance.

Each person who needed one had a medicines care plan including a list of all prescribed medicines and details of how they should be taken. This meant people were protected against the risks associated with medicines because the provider had appropriate arrangements in place.

One relative said, "They are very meticulous with gloves and aprons." Staff told us personal protection equipment (PPE) was available to protect people from the risks of infection. Staff we spoke with told us they wore gloves and aprons when providing personal care. This meant people were protected from the risks associated with infection.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us staff were able to support them well. Two relatives were complimentary about the skilled way in which care staff supported their relative whose behaviour may challenge others. One relative said, "They are on the ball. They point things out, for example [signs of a possible minor health issue]" A second relative said, "They don't waste any time. It's like an army invasion. I am absolutely very satisfied."

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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. For this type of service any applications to deprive a person of their liberty must be made to the Court of Protection (COP). No people currently using the service had a COP order in place.

The registered manager had a good understanding of their responsibilities if a person's rights were being restricted, for example if they lacked mental capacity and they were being locked in at home. They said they would refer this to the local authority safeguarding team and complete a risk assessment as well as involving the local fire service to assess the risks. They knew the person may need to be referred to the COP.

The registered manager and staff members we spoke with had an understanding of the Mental Capacity Act and it was clear from observations, feedback and records that people's autonomy, choices and human rights were promoted.

We found people had consented to their care plans where they were able to do so and relatives had been consulted in people's best interests for two people who may not have the mental capacity to make the decision. For these people their relatives had signed the care plan on their behalf and it was not clear from records if these relatives had power of attorney to consent on the persons behalf. During our inspection the nominated individual altered the consent to the care plan documentation to ensure it recorded any power of attorney held by a person's representative, or an assessment of mental capacity and a best interest discussion if required. We asked them to send us evidence this had been completed following our inspection.
We recommend the registered provider consults best practice guidance with regard to the MCA.

Physical, mental health and social needs had been assessed and care plans included guidance and information to provide direction for staff and ensure care was provided in line with current good practice guidance. The registered manager told us if a need for assistive technology was identified they would discuss this with the person and make a referral to the appropriate team.

Staff were provided with an induction, training, supervision and appraisal to ensure they were able to meet people's needs effectively. We looked at the training records for three staff members and saw training included infection prevention and control (IPC), emergency first aid, food hygiene, moving and handling, equality and diversity, privacy and dignity, the MCA and DoLS, safeguarding adults, dementia awareness, end of life care and diabetes. We saw from records training was up to date and further training was planned onto the rota.

Staff competence was also assessed in areas such as moving and handling and IPC. This demonstrated people were supported by suitably qualified staff with the knowledge and skills to fulfil their role.

Staff we spoke with told us they felt appropriately supported by managers and had regular supervision and an annual appraisal and we saw from records this was the case. One staff member said, "Yes I do feel supported. Definitely." Regular supervision of staff is essential to ensure people are provided with the highest standard of care.

People were encouraged and supported with meals and drinks, to ensure they maintained a balanced diet, if this type of support was required. Details of the meals eaten were recorded in people's daily records.

The service had good relationships with community health services and we saw the advice of professionals was included in people's care plans and used to achieve best practice and help people to achieve good outcomes.

Records showed people were supported to access external health professionals if the need arose. Staff and the registered manager told us they would have no hesitation in contacting a person's doctor or other community health professional if the person was unwell and unable to do so themselves.

Good

Is the service caring?

Our findings

People who used the service spoke positively about the staff and their caring attitude. One person said, "They are absolutely superb. Lovely and caring. They come and sit with me for a talk." A second person said, "Yes caring. Lovely staff."

One relative said, "Staff are always lovely and courteous. They are great with [my relative]. They have a lot of patience and a lot of care." A second relative said, "They are brilliant." A third relative said, "Excellent. Staff are caring, definitely. So wonderful. [My relative] likes the staff. They are really nice and chat to [my relative] when doing jobs. I can't praise them enough."

Staff told us they enjoyed working with people who used the service. One staff member said, "I love it." A second staff member said, "I absolutely love it. It's just meeting new people and you help someone else, you feel you are doing something really good." A third staff member said, "I've never looked back. I love it. Giving people company in their own home. It's lovely."

All the staff spoke to us about the people they supported in a caring, respectful manner and it was clear from conversations they knew people well. This included the registered manager and office staff. Staff could tell us how they supported people, including their personal likes and preferences.

The registered manager told us people were asked if they had a preference regarding the gender of the staff who provided their care as part of the initial assessment. This was recorded in the care plans we looked at and these personal preferences were respected.

The members of staff we spoke with were aware of how to promote the dignity and privacy of people who used the service. One staff member said, "Keep the person as covered up as you can during personal care. Close curtains and blinds. Give them space." This meant people's privacy and dignity was respected by staff members.

We saw people's confidential information was securely stored and people's private information was respected. Care plans were kept in a locked cabinet and staff were aware of the need to maintain confidentiality.

People's diverse needs were catered for and equality was promoted within the service. The registered manager told us how they had supported people who spoke community languages by matching them to a carer with the same skills. They told us they employed an ethnically diverse team and staff knew how to support the cultural needs of people from different ethnic and religious backgrounds.

People who used the service had been consulted about the care provided for them. People told us they made decisions about their care and were involved in planning their own support. We saw from care records this was the case. One staff member said, "Choice is a must. It's always the clients' choice."

People told us they were supported to remain as independent as possible in their daily lives and we saw from records they were encouraged to do what they could for themselves. This showed us the service had an enabling ethos which tried to encourage and promote people's independence.

Staff were aware of how to access advocacy services for people if the need arose. An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so for themselves.

Good

Is the service responsive?

Our findings

Through speaking with people, relatives and staff we felt confident people's views were taken into account and they were involved in planning their care. People told us they had a care plan in their home. One relative said, "At first they wrote a care plan. It's in the folder." A second relative said, "The managers did an assessment and met with [my relative], which was nice."

The registered manager told us when they took on a new client, they arranged to go and meet the person. They explained this enabled them to gather the information, along with the documentation they received from other health care professionals, to develop peoples care plan and risk assessments. Carers said if any amendments were needed to the care plan they fed this back to the registered person who made the necessary changes. This helped to ensure care plans were fully reflective of people's needs.

Staff told us they had chance to read people's care plans before delivering care. One staff member said, "We always read all the care plans before we start." Another staff member said the manager also discussed people's needs with staff.

The staff we spoke with had a good awareness of the support needs and preferences of people who used the service. Care plans also included personal information, such as the name the person liked to be known as and details of people's preferences such as how they liked to take their tea or coffee. This is important as some people who used the service had memory impairment and were not always able to communicate their preferences.

We reviewed three care plans. Each care plan recorded basic contact information as well as a service user profile. The care plans also included very detailed and person centred information about the support required at each visit. Care plans contained information in areas such as physical and mental wellbeing, daily living, hobbies, finances, communication, personal cleansing, skin, social, mobility and moving and handling.

All care plans had been reviewed regularly, were signed by the person and were up to date. These reviews helped to monitor whether care records reflected people's current needs so any necessary changes could be identified at an early stage.

The registered manager was not aware of the Accessible Information Standard. This requires the service to ask, record, flag and share information about people's communication needs and take steps to ensure that these needs are met. However, we found detailed information regarding people's communication needs and the communication needs of their relatives, where appropriate, was recorded in care plans. Staff told us how they used a variety of methods to communicate with people according to their needs.

People and relatives told us they would feel comfortable raising issues and concerns with any of the staff or the managers and they knew how to complain. One person said, "I have not had any problems at all. I have never had to complain. I would say to staff if I had." A second person said, "I would complain to [name of

staff member] if I needed to." One relative said, "I have no cause for complaint."

The service had a complaints procedure which was included in the person's contract agreement when they started using the service. The registered manager told us there had been one complaint, and we saw appropriate action had been taken to address it. One person had raised a concern with CQC prior to our inspection and we saw this had been dealt with appropriately at the time by the registered manager. No one we spoke with during our inspection raised any concerns or complaints regarding the service they received.

We asked the registered manager whether the service was currently supporting anyone who was at end of life and they told us they were not. The registered manager told us some people did not wish to discuss their end of life plans, however they intended to add a section to their care plan to record these should they wish to do so. Staff had received training in end of life care and the registered manager showed us positive feedback from family members where staff had previously supported their relative at the end of their life. We saw some people had a Do Not Attempt Resuscitation (DNAR) in place and a copy of this was kept in their care plan. This showed people's wishes regarding end of life care were recorded.

Good

Is the service well-led?

Our findings

People told us the service was well led. One person said, "Yes it's well organised. I have recommended them to a friend and they have them now."

One relative said, "It appears to be well led." A second relative said, "It's very well organised." A third relative said, "The service is fantastic. Absolutely brilliant. Yes, it's well led. [Name of care coordinator] is so helpful. Lovely. They have all done the grass roots care." A fourth relative said, "Yes it's very well managed. It's my only experience of a care service. I am really impressed. The three people in the office are absolutely amazing. They have supported me as well as my relative. They are so good, so approachable."

Staff spoke positively about the management of the service. One staff member said, "Yes it's well managed. I can't rate them higher. They always help." A second staff member said, "The manager is absolutely great. She pulls in where she can." A third staff member said, "It is improving all the time. It's really good. The best thing is knowing the managers are there for you and the service users. They listen."

The nominated individual and the registered manager were directors of the company and managed the service on a daily basis. They were both knowledgeable about people's individual needs and spoke with professionalism throughout the inspection.

The registered manager told us about the aim of the service. "We want to be the best at what we do. Provide good quality care. We give one hundred and ten per cent care. We would love to get a 'good' rating in all domains in a few years."

We found there was an open culture with a desire to improve systems and to provide person centred care. The registered manager operated an 'open door policy' in the office. They told us they encouraged staff to come in whenever they needed for support or advice. Staff we spoke with confirmed they were always welcomed.

We looked at systems in place to assess and monitor the quality and safety of the service provided. The management team completed regular recorded spot checks and observations of staff practice in the field. We saw audits were completed on people's daily records and MARs and any issues had been followed up with staff. This showed staff compliance with the registered provider's procedures was monitored.

People who used the service, their representatives and staff were asked for their views about the service and they were acted on. Regular reviews and quality assurance telephone calls to people and relatives were completed. A survey of people, families and professional had been conducted and the results of the 2017/2018 survey were very positive. The registered manager told us they read all the surveys and brought issues up at staff meetings if anything needed to be shared. They said they would compile the results to share with people and staff in the future. These systems demonstrated the service had effective quality assurance and governance processes in place to drive continuous improvement.

We saw monthly staff meetings had been held to discuss topics such as health and safety, confidentiality, the call logging system and staff training. Staff meetings are an important part of a registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care.

The registered manager told us they attended training and good practice events and had completed nationally recognised health and social care qualifications at level five. The management team worked in partnership with community health professionals to meet people's needs and drive up the quality of the service. We found there was never any delay in involving partners, such as social work and health teams, to ensure the wellbeing of people using the service.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. The inspection confirmed the registered provider was aware of their responsibilities to notify CQC and they had acted in accordance with the regulations.