Ark Home Healthcare Limited

Ark Home Healthcare Leeds

Inspection report

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Date of inspection visit:
06 November 2017
07 November 2017

Date of publication:
15 January 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 6 and 7 November 2017 and was announced. The provider was given 48 hours' notice because the location provides domiciliary care services and we needed to be sure that someone would be in the office. We contacted people who used the service and staff by telephone on 7 November 2017 to ask for their views. We also visited people in their homes on the 7 November 2017 to ask for their views.

Ark Home Healthcare Leeds is a domiciliary care service that provides personal care to people in their own homes within the Leeds area. Ark Home Healthcare Leeds was registered with CQC in December 2016 and this was the first inspection of the service.

The service provides care for people living with Dementia, learning disabilities, mental health conditions, physical disabilities and substance misuse problems for people under and over the age of 65. At the time of our inspection there were 292 people using this service.

The service had a manager who was in the process of applying to the CQC for registration. 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.

We found medicines were administered safely but administration was not always recorded correctly. Staff signatures to confirm they had supported people to take their medicines and other information written on the Medicines Administration Record Sheets (MARs) were not always recorded.

Regular audits had recently been introduced but prior to this there had been no consistency in monitoring and guiding improvements to the service being provided.

Some people who used the service did not have capacity to make decisions. We found people's care records did included capacity assessments and best interest forms however, not all relevant health professionals had been documented on the forms to be contacted if a best interest decision was needed.

People told us they felt safe when being supported by staff. Staff had a clear understanding of the relevant policies and procedures relating to safeguarding and whistleblowing.

Risk assessments were completed and reviewed to support people with specific needs to avoid any harm.

Staffing levels were adequate to meet people's needs. Staff were recruited in line with the providers policy, inductions took place and staff received appropriate training.

People were supported with their nutritional and fluid intake. People were also supported with their health needs.

People using the service and staff had positive relationships and people told us they felt well cared for.

People were encouraged to be independent and make choices regarding their care. Staff respected people's privacy and dignity when in their home.

Care plans were detailed and included relevant information such as initial assessments of need and instructions for staff to follow. People received personalised care which responded to their specific needs and preferences. Not all care plans had been updated to the new personalised planning however, the manager had an action plan for this and we saw this had been started.

Complaints had been responded to and appropriate outcomes had been recorded. Incident and accidents were managed and people using the service told us they felt confident to discuss any concerns with the provider. Lessons learnt were implemented to ensure practice was improved when incidents occurred.

All of the people we spoke with said the manager was approachable, supportive and listened to others.

Staff meetings took place and staff were encouraged to discuss proposed improvements for the service.

The manager provided clear visions for the future of the service and how improvements could be implemented.

Surveys were provided to people using the service, their relatives and staff to monitor the quality of the care provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

This service was not always safe

People received their medicines which were recorded in daily notes but not always on medicine administration records (MARs).

People told us they felt safe. Staff were trained to protect people against potential abuse and knew who to report this to.

Risk assessments were in place and were specific to people's needs and their home environment.

Staffing numbers were adequate to meet people's needs and safe recruitment processes were followed.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked capacity to make decisions, care plans did not evidence compliance with the Mental Capacity Act 2005.

Staff had received supervision in line with the provider's policy and there was an induction and training programme in place for staff.

People were supported to meet their nutritional needs and to maintain their health with access to healthcare professionals, if needed.

Is the service caring?

Good

This service was caring

People told us staff treated them with dignity and respect and showed due regard for people's privacy.

Staff provided explanations and involved people in their everyday care.

Staff supported the people to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were in place. These contained information about people's preferences and were regularly reviewed.

People were offered choices and these choices were respected.

Complaints were managed effectively and people told us they knew how to complain if needed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had recently introduced new style audits as previous audits were not effective in monitoring performance and improving the quality of the service.

The service had a manager who was in the process of applying to become the registered manager.

The service actively involved people, relatives and staff in the service and asked their opinion in order to learn any lessons and improve the service provision.

Staff and people who used the service were positive about the new management and felt supported.

Ark Home Healthcare Leeds

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 checked 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 was a comprehensive inspection. The inspection took place on 6 and 7 November 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service providing support to people in their own homes. We needed to be sure that someone would be available at the office.

This inspection was carried out by one adult social care inspector, one specialist advisor who had experience in safeguarding, one assistant inspector and two experts by experience. The experts by experience had experience of caring for a person with dementia and completed telephone interviews on the 7 November 2017. The inspector also carried out visits to people's homes on the 7 November 2017.

Before this inspection we reviewed information we held about the service. This included statutory notifications received from the provider and the Provider Information Return (PIR). The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what the service could do better and improvements they plan to make.

Statutory notifications are notifications of certain events and incidents that the provider has to inform the CQC by law. We used this information to help plan the inspection. We also contacted the local authority safeguarding team and Healthwatch.

During the inspection we spoke with 17 people who used the service, 10 relatives, the manager, and eight staff. We looked at a range of records including six staff files relating to recruitment, supervision, appraisal and training. We also looked at nine people's care records which included care planning documentation and daily records. We viewed records relating to the management of the service and a wide variety of policies and procedures.

Requires Improvement

Is the service safe?

Our findings

We looked at Medicine Administration Records (MARs) which were used to record when medications were provided to people. A MAR is used to document medicines a person has been prescribed and record when they have been administered. These were usually delivered in blister packs but individual prescriptions were also provided in separate boxes. Blister packs contain designated sealed compartments, or spaces for medicines to be taken at specific times of the day. They can help people to keep track of their medicines.

We reviewed 83 completed MARs and saw there were several gaps in recordings. We found one chart that had over 20 missed signatures over a four week period and another with 11 missed signatures. MAR's did not always clearly state the person's name or date of birth which did not follow the providers policy on documenting this to ensure staff knew who they were administrating medicines to. "As required" medicines were not always recorded correctly on MAR's. For example, one person had been prescribed Proshield cream to be applied as required but the MAR stated it should be given four times daily. We also found staff did not document times of when medicines had been administered. This demonstrated poor record keeping and highlighted a potential risk of over medicating.

We discussed this with the manager who told us they were aware of the improvements required with medicines management and had recently introduced audits on MAR's and actions for when an error occurred. Prior to this the manager told us that audits had been completed but these were not consistently followed up and checked until several months later. We saw the new system allowed staff time for MAR's to be audited at the end of each month. There was an attached matrix to document errors, to monitor trends and record any disciplinary actions taken should staff continue not to follow the provider's policy on recording medicines.

We recommended the service consider current NICE guidance on the management of medicines and take action to improve their practice accordingly.

We checked people's daily notes against the MAR's we looked at which showed medicines were being administered and this was documented in daily records. People told us they received their medicines. Comments included, "They always give me my tablets when I should take them, regular as clockwork" and "I have to take my tablets in a morning and they always make sure I've got them and taken them."

All the people and relatives we spoke to told us people were safe and comfortable with staff coming into their homes particularly when the same staff visited. People told us, "I feel safe because they always turn up and are willing to do things to help you, there's never any question of not being safe, I am quite satisfied" and "I am very satisfied with all the help, they look after me. I feel safe and comfortable with staff, they come the same time every day and if there is a problem they let me know."

Safeguarding and whistleblowing procedures and policies were followed. Staff had a clear understanding of how to report any suspected abuse and said, "Safeguarding is protecting anybody from harm." Another care worker told us, "I would report something straight to my manager. Physical, financial, mental, medical,

sexual, racism, I would report it to senior management. CQC, local authority or the police." Staff told us they felt confident to whistle blow and one person said, "Whistleblowing is reporting any wrongdoings, things you're not happy with. It would not bother me, I would report anything. As long as my service users are alright, I don't care what happens to me."

Safeguarding notifications identified a range of safeguarding issues including concerns raised by family members regarding staff, but also concerns raised by staff regarding service user's family. There was clear evidence of appropriate notification to the local authority in the form of safeguarding reports with clear outcomes recorded.

We found risk assessments were completed and some of these included assessments of pressure ulcers, moving and handling needs, finance and medicines. For example, one pressure ulcer assessment stated, "[Name] is at high risk of pressure sores. Care workers must ensure they check vulnerable areas each visit, ensure [Name] is clean and change pad. Apply prescribed creams and report any concerns to the office. Promote good fluid intake and ensure drinks are left within easy access." Another risk assessment for medicines asked the question, "Does [Name] have problems swallowing their tablets?" This meant the provider considered people's needs and put actions in place when required to prevent risk.

A contingency plan was available for staff to follow should an event happen where care could be compromised such as in bad weather. Telephone numbers were available for people to contact to support those they cared for.

Accidents and incidents were managed suitably, there were incident reports for concerns raised and clear evidence of actions taken. A staff member told us, "They (accidents) are recorded – I would call the office first and ask for guidance – I would document everything and make a statement and document what happened, when, who was involved – as much information as possible." People using the service told us they knew how to complain if needed.

Staffing levels were adequate to meet people's needs. Most staff we spoke to told us that more would be beneficial but overall the service was safe. Comments included, "I think they need more staff; more care workers. I don't think it's (staffing) is unsafe – it would just be helpful"; "Fine line between having enough staff – not unsafe practice – 90% of the time its fine. We have doubled up." "We're getting there; some areas do need more staff. We're constantly recruiting and training."

We looked at staff recruitment records which showed that appropriate processes and vetting checks were undertaken before staff began work. These included completing application forms, being interviewed, identity checks, reference requests and a Disclosure and Barring Service (DBS) check being obtained. DBS checks identify if prospective staff have a criminal record or are barred from working with vulnerable children or adults. We looked at six staff files and found they all included the relevant details.

Requires Improvement

Is the service effective?

Our findings

Not all of the people who used the service had the mental capacity to make informed choices and decisions about all aspects of their lives. 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. We discussed whether anyone in receipt of care from the service had an authorisation in place from the Court of Protection, to lawfully deprive them of their liberty in a community setting. The manager told us that to their knowledge none of the people they supported had such authorisations in place but should such authorisations be necessary in the future, they would pursue this with the relevant parties.

We checked whether the provider was working within the principles of the MCA and found capacity assessments had been completed for those who lacked capacity. Staff were knowledgeable about the MCA and best interest decisions.

Care plans identified if a person lacked capacity however, there had not been any best interest meetings recorded. We found best interest forms within care plans which directed staff to contact the person who had power of attorney or the person's next of kin to make any decisions. Two care plans we looked at stated, 'please contact [name's] POA in respect of any decisions relating to name' and 'consultation with appropriate others' but did not specify who this was. This meant not everyone involved in the persons care had been contacted to ensure relevant people were involved in the decision-making process. We discussed this with the manager who confirmed they had not yet completed any best interest meetings but would include all relevant people and planned to amend these forms. We also found best interest forms in care plans for those people who had capacity, this is not required if a person has capacity.

We recommended the provider research the MCA to ensure best practice is followed.

Care plans included consent forms and detailed when people were unable to sign. Relatives or staff would usually sign if the person provided verbal consent. Relatives and people using the service told us they were contacted by the provider to check if there were any care changes and to ensure they were happy with the care plan. Most people using the service were unsure if they had read their care plan but this was available in their home.

Induction programmes were completed by new staff. This included shadowing of established members of staff, being mentored for 12 weeks to check competencies, completing a work hand book and other training. The manager told us, they were in the process of recruiting care coaches to support new staff in completing the care certificate. The workbook had recently been updated and included welfare checks, shadowing

shifts, direct observations, development training and supervisions. This meant the provider was continuously improving and updating training to reflect current practice.

Staff were provided with annual training some of which included, end of life care, safeguarding, MCA, moving and handling, effective communication, health and safety, dementia awareness and medicines management. All staff had either completed their training or had dates for when this was due to be updated. We saw the manager kept a matrix to ensure staff kept up to date with relevant practice.

Staff told us they were regularly supported and had supervisions. We saw the manager had created a matrix to record when staff had completed their supervisions to ensure all staff had regular support meetings. Staff comments included, "[Management team] have really supported me. [Manager] has just started and gives lots of support. You don't have to make an appointment -you can just come in" and, "100% supported." Staff also told us they were encouraged to enhance their learning and development. One staff member said, "Yes. I've only been with the company a short time but I was speaking with [Manager] today about my career, about progression and she described a new program for care coaches."

People using the service were supported with their nutrition and fluid intake for example, one person had difficulties holding items in their hands. Within the care plan it stated, 'Ensure you cut up [Name's] food into small enough pieces so that [they] find it easy to pick the food up to eat.' People using the service and their relatives told us they received help with food and told us they were given meals of their choice. People were left with flasks for drinks and snacks between calls or their teatime sandwich was left for them.

People were supported to access a range of healthcare professionals, including GP's and occupational therapists. One person using the service told us when they required equipment in their home this was arranged by the provider within a week and the problem resolved. Another person said, "They ask if everything is okay and if you are not well they get in touch with the doctor."

Good

Is the service caring?

Our findings

The people and relatives we spoke to were very positive about the regular staff and told us they were kind, caring, chatty and friendly. People also told us staff treated them with dignity and respect and showed due regard for people's privacy.

We found care plans identified people's diverse needs and included details of people's ethnicity and their preferred spoken language. One care plan outlined specific care staff should undertake which was related to the person's religious belief.

At one visit, we observed staff chatting with the person who used the service and having jokes. When physical interventions were required staff provided explanations at each stage so the person knew what would be happening and asked if they were comfortable. For example, staff said "Are you ok? Do you have any pain in your knees?" We also saw staff explain where items in the home were so that the person could access these once they had left.

When visiting people in their homes we saw staff knock on doors and introduce themselves to people using the service. On one occasion staff had asked the inspector to leave the room whilst they used the hoist, they told us the person was very private and as the intervention would expose her she wished to do this with staff who knew her. Another person was provided a choice of food for their lunch and staff knew to leave the lunch with the person as they preferred to eat in private once the staff had left. The person using the service said, "I like to eat in private", staff respected this. A person using the service told us, "Yes, they respect my privacy, they come in the bedroom to wake me up, help me in the shower but keep me covered up and leave me to dress myself."

People living at home were supported to remain independent if their health allowed. One person had variable ability depending on the day and the care plan supported this. It stated 'Sometimes [Name's] mobility can vary and maybe able to stand independently to transfer or [they] may require hoisting to the commode. Transfer either with walking aids or hoist to the living room.' Staff told us, "We encourage them to do things themselves. Once you take something away from them, they won't get it back." One person who used the service told us, "[Staff Name] is like a friend, knows me well. I am very independent and she totally respects that, she recognises what I can do for myself but she would do it if needed."

At the time of our inspection no-one using the service had an advocate. Advocates help to ensure that people's views and preferences are heard. Staff we spoke with and the manager had a good understanding of what an advocate's role was and how they could support people. The manager told us they would contact social services to arrange for an advocate should this be required.

Information about people was kept securely in the office and locked in a cupboard at all times. Staff told us they were aware of keeping personal information confidential and knew how to access this information. The manager told us information was also kept in people's homes.

Good

Is the service responsive?

Our findings

Initial assessments were completed by the provider or in conjunction with social services. We found people were asked about their preferences and this was incorporated into people's care plans. Care plans were person centred and specific to people's needs. Pen portraits were completed including details about the person. For example, 'I used to work as a sales manager and have also worked in [company name] canteen.' This supported staff to build relationships with people using the service and to use this information as a platform for discussions.

People we spoke with did not comment on any social activity support they received. Staff told us they would do activities with people but only if this was part of their agreed care package and it was documented in their care plan. For example, one person's pen picture for goals and objectives stated 'I have recently been very fed up and depressed. I have some socialising twice a week and I really want them to boost me so I am not feeling down as much.' Under the 'My interests' section of the care plan, the person had identified pamper days, hair and makeup as activities they enjoyed. We found the activities recorded included these activities which meant staff were responsive to people's needs and promoted wellbeing.

Care plans were individualised and provided people with choice. For example, one person had requested a certain breakfast in the morning which stated, 'I usually have jam on toast or bread and a coffee with milk and one sweetener.' Staff told us, "You can introduce foods by offering them something extra, like an alternative. It's about offering choices. You respect people."

We saw care plans included 'emergency transfer' forms providing details of people's medical history and other essential information to support people when transferring into hospital. This meant a smooth transition from a person's home to another service could take place.

The manager told us they were currently in the process of updating all care plans to make them more person centred. We saw this had been started and 72 care plans had been updated with an action plan for the remaining care plans to be changed over the coming weeks. The manager had also introduced formal reviews of care plans on a regular basis to ensure needs were consistently being met.

We saw there had been nine complaints within the last 12 months, all of which had been responded to in a timely manner with actions taken when required. This included witness statements, letters of apology and lessons learnt. We found the provider had a flow chart to follow process to ensure all complaints were managed effectively. For example, one complaint was made after a person did not receive their medicines as it was out of pharmacy hours and staff were unable to get the medicines. The lessons learnt included information for staff on how they are able to obtain medicines during out of hours to ensure everyone receives their medicines. People using the service told us they did not have any complaints but would know how to contact the provider should there be a need.

The provider received 19 compliments from July 2017, nine of these were from October 2017 and we saw thank you cards from people.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the manager was new into post but had already identified areas for improvement. The manager told us that previous audits had not been completed and we found recording was poor on medicine administration records (MARs) and in audits. The manager has now planned for these to be done on a monthly basis to identify what improvements should be made.

The manager had not yet registered with the CQC but was in the process of doing this. They had previously worked as the deputy manager so had a good overview of the service. The manager commented on several projects that she was focusing on to improve the quality of the service. They included updating all care plans to ensure they were person centred and included relevant information. They were also fully aware of the issues with regards to medicine recording and had plans to address these concerns with regular audits and subsequent actions should staff not follow correct procedures.

Audits introduced by the manager were now more effective because the data collected was analysed and the information used to identify trends or themes, The manager confirmed they planned to do monthly audits of medicines due to the lack of recording found on MAR's however; there was still a back log of audits to be completed from August and September. The manager told us they planned to complete these audits at the end of each month to ensure actions were taken immediately rather than some time after. The manager had introduced a matrix to identify medication errors or recording issues with agreed actions to take should this be repeated which included supervisions with staff through to disciplinary actions.

Safeguarding referrals, complaints, compliments, incidents and accidents were all recorded on the providers 'cold harbour' system and a weekly report was sent to their head office for data collection and analysis. This was also done for staffing levels and the manager told us they had weekly meetings with human resources to ensure the staffing levels remained adequate.

The manager kept a matrix which they updated monthly for missed calls and incidents. This was also reported to head office. We saw in August there were two missed calls and September had one missed call. Actions had been taken when there had been a missed call to find out why this had happened and how such events could be avoided in the future.

Staff were positive in their comments about the new manager and the changed culture. Staff told us, that management were supportive. Comments included, "[Manager's name] is there, and [Manager] is just at the end of the phone. Everybody has the phone number. [Manager] has supported me on a personal level, is approachable and good to talk to. [Manager] is visible. I feel much better now, but I wouldn't have done before Manager started." Another person said, "The culture is caring, supportive, informative, would feel confident in raising concerns, I have no problem speaking my mind in a respectful way. They listen and take it into account. It's a different world of care." Another commented, "We all work together, it's a happy working environment. The manager is approachable, even though she is new to the position."

Staff and the manager told us monthly staff meetings took place. One staff told us, "We talk about new

positions coming up, it's an open floor. If anyone has concerns to share they are shared. We share tips. Training and help/questions and answers; you don't feel intimated, it's relaxed."

People's views of the service were collected through surveys. Surveys were sent by the providers head office to people using the service, their relatives and staff on a six-monthly basis. The last survey was sent in October and the manager told us they had not yet received the data for this so we looked at the previous data from surveys completed in November 2016. Overall 85% of people using the service 'very/satisfied' with the care they received and 86% of staff said they enjoyed their role and responsibilities.