Ashbourne Group Limited

Ashbourne Healthcare Services

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 15 and 22 February, 22 March and 28 April 2016. The first day of the inspection was unannounced. At our previous inspection on 2 May 2013 we found the provider was meeting the regulations we inspected.

Ashbourne Healthcare Services is a domiciliary care agency providing personal care and support to people living in their own home. At the time of this inspection the provider was providing personal care services for 20 people.

The service has a registered manager. 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 did not always feel safe using the service and one person was intimidated by a care worker after they reported their concerns. Staff did not demonstrate a clear understanding of how to protect people from abuse and the provider did not consistently inform appropriate organisations about safeguarding concerns. Staff were not aware of how to whistleblow about any concerns relating to the conduct of the service.

Staff had received medicines training, however records showed that the policy and practices for applying prescribed topical creams and lotions were not safe.

There were sufficient staff to meet people's needs and a detailed recruitment process was carried out prior to staff commencing employment.

We received mixed opinions from people in relation to their experiences of staff punctuality and reliability, although people confirmed that they were supported by a small number of staff so that consistency and stability was achieved.

Records showed that staff had received training but events at the service indicated staff needed additional training. The provider evidenced that staff gained practical experience of care and were monitored during a placement at a care home for nursing. However, we did not find robust systems to show that the provider checked on people's learning after they had completed training.

Monitoring visits to people's home included some checks in regards to staff performance and conduct but there was no evidence of one to one formal supervision, so that staff had individual support to effectively undertake their responsibilities.

Care planning records showed that people's capacity was assessed, however staff did not appear to be familiar with the Mental Capacity Act 2005 (MCA). This meant staff did not understand the principles about

people's rights to make choices and decisions.

People were provided with the support they required to meet their needs with meals and healthcare. We received positive comments about how the provider had met the needs of people receiving palliative care.

People's entitlement to dignity and confidentiality were not always respected. There were clear issues of concern about how some staff disregarded professional boundaries in terms of how they spoke about people who used the service and there was a lack of compassion for people who were vulnerable due to their healthcare needs.

The terms and conditions for people who were self-funding contained stringent requirements for people to report any discrepancies or queries about timesheets they had signed within four days. This did not appear realistic or sensitive to the needs of people who used the service, and did not appear to consider that the impact of their ill-health, frailty or disability could lead to extended periods when they were unable to check timesheets.

Assessments and care plans did not evidence that staff knew people's needs and wishes well. There was a lack of details about people's wishes, interests, cultural requirements and other preferences to enable staff to provide a personalised service.

People's needs were assessed before they received care and this information was used for care planning. However, we found that one person did not have an appropriate care plan and accompanying risk assessments because the provider had not understood that they were providing personal care to the person. This resulted in the person not receiving the care and support they needed.

People's views were sought through the use of questionnaires and telephone monitoring calls.

The management team did not demonstrate a comprehensive knowledge of the responsibilities associated with providing a regulated service.

We have made a recommendation to the provider regarding information within the provider's terms and conditions for self-funding people, which did not appear to take into account the circumstances of people who require support with their personal care needs.

We found six breaches of Regulations. One was in relation to the provider not informing the Care Quality Commission about safeguarding allegations. The other breaches related to one to one formal staff supervision, the provision of respect, dignity and confidentiality for people who use the service, the need for the provider to correctly identify and address people's needs for personal care, effective identification of complaints and the need for better systems to assess, monitor and improve the quality of the service people receive.

You can see what actions we asked the provider to take at the back of the main report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff did not demonstrate their understanding of how to protect people from abuse and the provider did not consistently inform appropriate organisations about safeguarding concerns.

Accurate guidance and training for staff was needed to ensure people were correctly supported to use prescribed medicines in the form of topical applications.

There were enough staff to meet people's needs and a robust recruitment process was undertaken prior to staff commencing employment.

Is the service effective?

Requires Improvement

The service was not always effective.

Records showed that staff had received training but events at the service indicated staff needed additional training, and individual support through formal supervision.

Care planning records showed that people's capacity was assessed, however staff were not aware of their responsibilities under the Mental Capacity Act 2005.

People were provided with the support they required to meet their needs with meals and healthcare.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not consistently provided with a service that respected their right to dignity and confidentiality.

Assessments and care plans did not evidence that staff knew people's needs and wishes well.

Positive comments were received about the care and support provided for people with palliative care needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed before they received care and this information was used for care planning.

The provider did not understand the range of care and support that comprised personal care, which resulted in one person not receiving an appropriate service to meet their needs.

Complaints and how they were responded to were not recorded by the provider.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems were in place to seek the views of people who used the service.

The management team did not demonstrate a comprehensive knowledge of the responsibilities associated with providing a regulated service.

Ashbourne Healthcare Services

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.

The inspection took place on 15 and 22 February, 22 March and 28 April 2016 and the first visit was unannounced. We gave the provider 48 hours' notice that we would be visiting the service. This was because the service provides care to people living in their own homes and we wanted to make sure that key staff would be available to speak with us.

The inspection team consisted of one adult social care inspector for two visits, two adult social care inspectors for one visit and one adult social care inspector and an adult social care inspection manager for one visit.

Prior to the inspection visits we reviewed information we held about the service, including any statutory notifications submitted by the provider to the Care Quality Commission. A notification is information about important events which the provider is required by law to send to us.

On the first and second days of the inspection we looked at a variety of records, which included five people's care files, five staff recruitment folders, staff training, supervision and appraisal records, policies and procedures and other documents in regards to the operation of the service. We spoke with the registered manager, the care co-ordinator and the managing director.

Following these two days, we spoke by telephone with one person and the relatives of three people who used the service and two members of the care staff. Three health and social care professionals with knowledge and experience of the service were contacted for their views and we received one response. We

visited the provider on two further dates in order to seek additional evidence following the receipt of information from a person who used the service.

Requires Improvement

Is the service safe?

Our findings

People gave mixed responses when we asked if they felt safe when they used the service. One relative told us, "The staff are lovely and make [my family member] feel very comfortable in their presence." One person who used the service told us they felt intimidated by a staff member who attempted to coerce them into falsifying a timesheet. This concern was reported to the provider by the Care Quality Commission. The provider submitted a safeguarding alert to the appropriate local authority following our request to do so, and took disciplinary action in relation to the behaviour of the employee.

We asked two care workers to describe the different types of abuse people who used the service might be at risk from. Both staff members presented a limited understanding of safeguarding and demonstrated no knowledge of the provider's whistleblowing policy. (Whistleblowing is the term used when a worker passes on information concerning wrongdoings). We advised these staff members to ask their line manager for training and support to address their deficits of relevant knowledge, and spoke with the registered manager about our findings during this inspection. The registered manager provided information to demonstrate that all staff were scheduled to receive refresher training to address their understanding about safeguarding people and whistleblowing.

The provider's safeguarding policy and procedure contained information about how to report safeguarding concerns. During the inspection we received information to indicate that a person who was assessed to require two staff to jointly safely deliver their personal care had not consistently received this level of care. This was because one member of staff had not turned up on more than one occasion and failed to advise the provider, so that an alternative staff member could have been allocated. We discussed this finding with the registered manager, who informed us that the person was supported on these occasions by their relative and one care worker. This placed the person and their relative at risk of harm, as the person needed the assistance of two staff who had been trained and assessed for their competence to safely meet their identified moving and positioning needs. The registered manager did not understand the risk of a person who had been assessed to require assistance from two trained care workers instead receiving this support from one care worker and a relative. There was no information in the care file and no risk assessments to state that it was safe and appropriate that the relative should step in and take over when a care worker did not turn up. We noted the provider had not notified the relevant safeguarding team or the Care Quality Commission. We asked the registered manager to submit a safeguarding alert, which was carried out.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

The provider informed us that some people who used the service did not require any support with managing their medicines, as they undertook this independently or were supported by a family member within their household. We looked at the provider's medicines policy and care files for people who needed prompting with their prescribed medicines. We noted that some care plans instructed care workers to assist people with the application of prescribed topical creams and lotions but did not state the names of these medical items. This meant that staff did not have clearly recorded accurate information to ensure that people received the correct personal care in regards to their individual medicines needs. Guidance in 'The Royal

Pharmaceutical Society: The Handling of Medicines in Social Care' affirms, "When care is provided in the person's own home, the care provider must accurately record the medicines that care staff have prompted the person to take, as well as medicines care staff have given." We discussed this with the registered manager. During the inspection amendments were made to the provider's medicines policy and we were informed that people's care plans had been updated to include full details of any topical creams and lotions that staff assisted people to apply.

People's care files demonstrated that risks to people's safety had been identified. The risk assessments addressed people's individual needs, for example, if people were at risk of developing pressure sores or at risk of experiencing falls. Guidance was provided for staff to manage these risks. There were also environmental risk assessments for areas in a person's home. For example, there were checks to make sure that people were not being supported to receive personal care in rooms that were cluttered with obstacles or had loose mats that people could trip over. Staff told us they understood the provider's policies in relation to reporting any accidents or incidents, which involved telephoning the on-call line manager for advice and documenting any events in the person's daily records.

The provider demonstrated robust recruitment practices, which meant people were not placed at unnecessary risk of receiving their personal care and support from inadequately recruited and unsuitable staff. Appropriate checks were carried out before new employees commenced work, which included Disclosure and Barring Service (DBS) checks. (The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people). We noted that the provider obtained a minimum of two written references, proof of identity and proof of eligibility to work in the UK.

People and their relatives told us they received their care from staff they knew. A relative told us their family member had developed positive relationships with their regular care workers. They praised the provider for minimising any possible disruption to the smooth running of the service to their family member when a principal care worker was on leave, by allocating other familiar care workers. People and their relatives informed us they had not experienced any shortages of staff and thought the provider employed sufficient staff to ensure that their needs were met. One person who used the service and the relative of another person told us they had experienced difficulties with staff punctuality, which they had reported to the provider. One person stated that this had resulted in some improvement with staff punctuality and another person said that their issues of concern had not been properly resolved.

Records showed that staff had received training in relation to infection control. Staff told us they were provided with protective personal equipment (PPE), including disposable gloves and aprons. The unannounced spot checks by the care co-ordinator monitored whether staff were correctly using PPE and adhering to standard infection control practices such as the use of designated plastic bags for clinical waste.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they thought that their care workers had appropriate training and support to meet their needs. One relative told us that they spoke with the provider when they were not satisfied with how staff provided their family member with personal care and improvements were made.

Records showed that there was a programme of staff training available, which included safeguarding adults, moving and positioning people, basic life support, health and safety, supporting people with their medicines, and basic food hygiene. Staff were scheduled to attend training to understand how to support people living with dementia, and pressure area care training to support people who had developed or were at risk of developing pressure ulcers. The managing director informed us that new staff spent at least one week on a supernumerary placement at a care home with nursing owned by the provider, as part of their induction. This provided care staff with an opportunity to develop their skills and knowledge under the supervision of qualified nurses before they commenced their roles within the domiciliary care agency. The registered manager informed us that all new staff completed the 'Care Certificate', which is an identified set of standards that health and social care workers adhere to in their daily working life.

Discussions with care staff indicated that although they had attended an induction course and other training, they were not able to clearly explain their understanding of routine care practices. During the inspection we received information that demonstrated that some staff did not understand professional boundaries and how to maintain confidentiality. We discussed this finding with the registered manager, who provided documentation that evidenced the induction training covered these issues. We were sent additional information to show that the provider had developed refresher training for all staff, in order to reiterate the importance of professional behaviour at all times.

Staff told us they felt well supported by the management team, through one to one supervision, appraisals and regular contact with their line manager. We looked at the one to one supervision records and found that these were 'spot checks' conducted at people's homes rather than formal supervision sessions that enabled staff to highlight any issues of concern related to their work, and discuss their learning and development needs. We discussed this finding with the registered manager. During the inspection we were presented with a new supervision document that incorporated systems to check that staff were being supported by the provider to carry out their roles and responsibilities. We noted that people received appraisals and daily communication took place between the registered manager and/or care co-ordinator and care staff, which enabled staff to seek advice and guidance.

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

As the service provided care and support to people who at times did not have capacity to make certain decisions, we checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA). 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. Some care files had been signed by people who used the service and their capacity to make decisions was documented. The provider understood that relatives could consent for people only in circumstances where they held a lasting power of attorney for health and welfare decisions. The care staff we spoke with were not aware of the MCA and how it impacted on protecting people's rights.

People and the relatives we spoke with were assessed as not requiring support from care staff with preparation of meals or support with eating and drinking. We noted that people's care files contained information about their nutritional needs, where necessary. This included details about preferred food and drinks, any special diets for medical and/or cultural needs, and how people wished for their meals to be prepared. The service used fluid and food charts, and weight monitoring charts, if a person was assessed to be at risk of malnutrition.

We noted that people who used the service or their relatives dealt with people's healthcare appointments. Records within people's care files showed that referrals were made to health professionals, for example the provider had informed community nurses when a person was noted to have developed a pressure sore and another person presented with symptoms that indicated the presence of an infection. This showed that staff observed for significant changes in people's health and wellbeing, and the provider ensured that appropriate healthcare professionals were contacted for their specialist input.

Requires Improvement

Is the service caring?

Our findings

Comments in relation to attitudes and approaches by staff were mixed. One relative expressed their complete satisfaction about the staff assigned to their family member, "They are all very nice girls, [my family member] looks forward to seeing them and wouldn't be without them." Another relative said that staff were polite and interacted gently with their family member. However, one person told us they felt intimidated by two members of staff and did not think that these members of staff had behaved in a respectful and compassionate manner. The relative of a person who used the service expressed mixed views about how care staff had conducted themselves. They told us they had been upset when care staff falsified timesheets and left early. The relative said they reported this to the provider and improvements were made.

Care staff explained to us how they ensured people's privacy and dignity when providing personal care. For example, care staff stated that they asked people for their consent before commencing a wash or a shower, made sure that curtains were pulled and doors shut, and used towels to cover people as required during the delivery of their care. Staff were aware of the importance of not sharing information about the people they supported with other persons or organisations, unless the information was needed by health and social care professionals involved in people's healthcare, safety and welfare.

However, we received information from a person who used the service which demonstrated that a member of staff did not behave in a professional manner that promoted people's entitlement to dignity, respect and confidentiality. The staff member told the person about two other people who used the service, including personal information about people's diagnosis, healthcare needs, family composition and friends. This showed that the care worker did not understand the importance of ensuring that people's privacy was protected. We discussed this finding with the provider, who informed us that all staff would receive refresher training about the provider's code of conduct.

Other information from a person who used the service showed that some staff did not understand important aspects of how to maintain professional boundaries. We noted that two care staff had communicated with a person who used the service using a social media network and a staff member contacted a person who used the service after they had been suspended from work for alleged abuse of the person.

This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We received information from an external professional in regards to how the provider supported people with palliative care needs. We were informed that the service had provided good care for people with complex needs and people had given positive feedback about their care workers. For example, one care worker was highly regarded by a person and their relatives as they had used their initiative to provide compassionate and thoughtful care which had made a tangible difference to the comfort and dignity of the person during the final stage of their life.

Care staff told us that they got to know people and spoke with people and/or their relatives to find out more

about their interests, likes and dislikes. We noted that most of the care files we looked at had limited information about people's background, cultural needs and preferences. The absence of this information meant that it could be difficult for staff to provide a personalised service, for example to initiate meaningful conversations with people or support them to listen to their favourite music. This personalised approach could positively enhance people's experience of receiving care, particularly people living with dementia and other healthcare problems that might lead to feelings of isolation, and people receiving palliative care. We discussed this finding with the registered manager who stated that they planned to amend the assessment forms so that additional biographical and social information could be sought from people who wished to provide these details.

People were provided with information about how the service operated, which included contact numbers and advice about how their queries would be dealt with out of regular business hours. We noted that the 'terms of business' document for people who were self-funding stated that there was a narrow timescale of four days for people to inform the provider if they had any queries about timesheets. This did not appear to take into account the difficulties people could reasonably encounter with getting in contact with the provider if they were unwell, in hospital, experiencing difficult personal circumstances or wished to consult with a relative or friend before raising query. This did not demonstrate that the provider was adequately considering people's needs in relation to their procedures in order to ensure that people were supported to raise any concerns about their timesheets.

We recommend that the provider seeks advice from a reputable source to review the content of the terms of business for self-funding people.

Requires Improvement

Is the service responsive?

Our findings

Care files demonstrated that people's needs were assessed prior to the commencement of their service. The care files we looked at contained assessments conducted by people's social workers or other professionals. The registered manager confirmed that some people who used the service were self-funding, therefore their assessments were conducted by the provider only. The type of assessments varied, for example some people were funded via NHS Continuing Care arrangements and had detailed assessments that looked at all aspects of their healthcare needs.

The provider then conducted their own assessment, which was more focused on people's daily routines and how they wished to be supported at home. The assessments were used to develop people's care plans. We noted that the care plans were kept under review and were updated in accordance with any significant changes in people's needs and wishes.

During the inspection we received information from a person who was receiving personal care. However, we found that the person's name was not included in the provider's list of people who used the service for personal care, which we had obtained from the registered manager as part of the inspection process. We discussed this finding with the registered manager and discovered that the person had not been recognised by the provider as a recipient of personal care, although they were receiving daily support to get dressed. The provider informed us that they had regarded the person as being a client for domestic support only as they had not known that support with dressing was defined as personal care. The person had not received an accurate assessment of their needs by the provider which meant that care staff did not have suitable written guidance and support about how to meet the person's needs in a manner that took into account the person's preferred routine, wishes and any health or safety related factors. (The Care Quality Commission does not regulate services for people who receive domestic support packages, unless there is a personal care element). This indicated that the provider did not fully understand the nature and scope of the regulated activity that it had registered with the Care Quality Commission to provide.

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider informed us that they had not received any verbal or written complaints since the previous inspection. This information did not correspond with comments from the relative of a person who used the service, who told us about the verbal complaints they had made to the provider. We also found that another person had made several complaints which we were not informed about. The provider explained to us that this was due to the person not being recognised as a user of personal care services, although their care plan clearly stated the delivery of personal care. People were provided with written information about how to make a complaint, however the provider did not appear to recognise the need to make a record of verbal complaints with information about how the complaint was resolved. This meant the provider did not have an accurate record of complaints received from people who use the service, their relatives and other relevant parties, with accompanying written records of the actions taken and evidence of any learning that took place from complaints.

This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

At the time of this inspection the service was managed by a registered manager, who was supported by a care co-ordinator. The care co-ordinator was a registered general nurse and was responsible for carrying out assessments and conducting spot checks at people's homes, in addition to other duties.

One relative told us they thought the service was well managed. They described the office staff as being helpful and found that the care for their family member was properly organised, for example, no difficulties arose if the regular care worker was on leave or off work due to illness. Other people expressed more mixed views about the management of the service. One person told us that they had not received satisfactory responses when they raised concerns about the punctuality and reliability of their care workers and how this negatively impacted on their ability to live as independently as possible.

We found that the provider carried out regular spot checks to monitor the quality of the service people received. The registered manager told us about the provider's plan to introduce a new electronic monitoring system which would enable care staff to provide instant information about how they had met people's care needs. There was evidence to demonstrate that the provider took action if staff were observed to not be delivering personal care and support in accordance to the specifications of people's care plans and the provider's own standards for conduct. For example, we saw that the provider took disciplinary action in response to an employee's lateness. The provider sought people's views about the quality of the service through the use of questionnaires and through telephone monitoring checks and staff told us they felt well supported by the management team.

Several concerns were identified during this inspection in relation to how the service was managed. These concerns included the effectiveness of how the provider checked that staff understood the training they had attended, given that we spoke with two members of staff that were unclear about how to safeguard people from abuse, how to whistleblow and the importance of understanding people's capacity to make their own decisions. Gaps in staff training, support and knowledge were also apparent when it emerged that a staff member inappropriately discussed confidential information about other people who received a service with a person who used the service and two staff members inappropriately contacted a person using the service via social media. Other concerns included the provider's inability to recognise that a person was receiving personal care within their care package and the failure to identify and report potential and actual safeguarding concerns to the relevant safeguarding team, and notify the Care Quality Commission in line with legislation. It was noted that the provider took action to address issues of concern that we brought to their attention. For example, when we identified that two members of staff were not able to discuss their understanding of safeguarding people and whistleblowing, the provider organised refresher training for the staff team.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider did not protect people who use services by notifying the Care Quality Commission without delay about risks to their safety and wellbeing. Regulation 18

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not design care with a view to achieving a service user's preferences and needs were met Regulation 9 (3)(b)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that people who use the service were treated with dignity and respect at all times Regulation 10

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not operate an effective system for identifying, receiving, recording, handling and responding to complaints. Regulation 16 (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider must ensure that effective systems are in place to assess, monitor and improve that quality of services provided. Regulation 17 (1) (2)(a)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who use the service were not protected from the risks associated with staff not receiving appropriate supervision to enable them to carry out their duties. Regulation 18 (2)(a)