Care Quality Commission

Agincare UK Limited

Agincare UK Newcastle under Lyme

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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 1 October 2015 and was announced. The provider was given 48 hours notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to speak with us.

The service provides personal care to people who live in their own homes. At the time of the inspection there were 147 people using the service. There was a registered manager in post.

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 that some people did not have specific risk assessments or plans to show how risks were minimised.

Summary of findings

Some people's care plans were not reviewed to ensure they met their current needs. People with complex needs in relation to eating and drinking did not have detailed, up to date plans in place for staff to follow.

People told us they felt safe and that staff were friendly and caring towards them. However, people told us that staff were sometimes late for their calls without informing them. Staff were aware of how to recognise and report abuse and we saw that referrals to the local authority had been made when needed in order to keep people safe from unnecessary harm and abuse.

Some people who used the service were not able to make decisions about their care and support. Assessments of their mental capacity did not show how people were supported to be involved in decision making. Some people had attorneys to make decisions on their behalf but the service did not have copies of the legal documents to ensure the right people had been involved in making decisions in people's best interests.

People told us that staff had the right skills to support them and we saw that staff had completed training. Staff felt supported by the registered manager who offered additional support to staff if required.

People told us that staff treated them with respect and supported them to be independent. However, some people felt that staff rushed them. People valued the relationships with their regular staff and felt that regular staff had made an effort to get to know them.

Care records did not always contain the information staff needed to enable them to keep people safe and meet people's individual preferences and needs. People's care plans were focussed on tasks and did not describe how individuals liked to be supported. Staff told us that they knew people well and that consistency was improving following changes made by the registered manager.

There was a range of ways that people could feedback their experiences to the registered manager and we saw that complaints were dealt with in a timely manner. The registered manager had systems in place to monitor quality and was working on a number of ways to improve the quality of the service.

The management did not have a clear oversight of staff backgrounds. We found examples where staff needed a risk assessment to ensure that they were suitable to work alone with people in the community and this had not been done. We found that medication records were not fully and accurately completed. These issues resulted in a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not consistently safe. Some people's specific risks were not assessed to keep them safe from harm. People told us they received their medicines as prescribed, however there were gaps in the recording of medicine administration. People felt safe and staff knew how to recognise and report abuse.	**Requires improvement**
Is the service effective? The service was not consistently effective. Some people were unable to make their own decisions. Assessments of their mental capacity did not show how people were involved and supported to make decisions. Not all staff had a good understanding of how to protect people's legal and human rights. Where people had complex needs in relation to eating and drinking, they did not always receive the support outlined in their care plan. Staff received training and support to carry out their tasks and the service contacted professionals for support when needed.	**Requires improvement**
Is the service caring? The service was caring. People told us the staff were friendly and treated them with dignity and respect. People felt that staff made an effort to get to know them and listened to what they said. Staff supported people to be as independent as possible.	**Good**
Is the service responsive? The service was not consistently responsive. People felt their regular staff knew them well but care plans did not reflect people's individual preferences and were not always up to date. People knew how to complain and we saw that complaints were responded to in a timely way by the manager.	**Requires improvement**
Is the service well-led? The service was not consistently well-led. The management did not have a good oversight of staff backgrounds to ensure they were suitable to work with people who used the service. Medication records were not fully completed and gaps were present with no explanation. The registered manager completed quality checks and was aware of some but not all of the issues identified at inspection. Staff felt supported by the manager who was implementing changes.	**Requires improvement**

Agincare UK Newcastle under Lyme

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 1 October 2015 and was announced. The provider was given 48 hours notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to speak with us.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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. We reviewed this information alongside information from the local authority and members of the public.

We spoke with 15 people who used the service, two relatives and a close friend of a person who used the service. We also spoke with two social care professionals, five members of staff and the registered manager.

We looked at the care records for five people who used the service to see if they were up to date and reflected the care received. We also looked at six staff files, accident and incident forms, complaints records and other documents to help us see how care was being delivered, monitored and maintained.

Requires improvement

Is the service safe?

Our findings

Risks were not always assessed to ensure that people were kept safe. Specific risk assessments were not in place to manage people's identified risks. One person who used the service said that staff should supervise them when they ate because they were at risk of choking. There was no specific choking assessment to identify potential risks or show what was being done to reduce this risk. Staff knew the person had a specialist diet but were not clear about the specific support the person needed to manage their risks. The person's care plan said they needed assistance to eat a pureed diet. The person said they were not always supervised and staff were not clear about what assistance the person needed. This meant that risk was not suitably assessed, monitored and reviewed to keep people safe from harm.

People told us that where the service supported them, they got their medicines as prescribed. However, we saw that some people's medication administration records (MAR) were not fully completed. We saw that there were gaps in medication records and no explanation of the reasons for these gaps were recorded. This meant there was a risk that people were not receiving their medicines as prescribed. One staff member told us that some staff did not complete the records correctly and this meant that staff could not be sure if the person had received the correct dose.

People said that the staff did not always come at the agreed time or stay for the stipulated time. One person said, "Some get away quickly. They always say they are busy." Another person said, "They don't stick to times. They sometimes arrive late. I never really know what time they are going to arrive, the times are all different." Records showed that sometimes, calls delivered were shorter than the times agreed. Some people told us they were kept waiting to be helped to get up in the morning or waiting to go to bed at night. One person said that they got up at 6am and liked to go to bed early but this frequently did not happen because the staff were late in arriving. One relative said "[Person who used the service] will have been sitting in the chair for 12 hours. When they are late, [Person who used the service] will try to do as much as they can for themselves and that is when accidents happen."

People told us they were not always informed if their visit was going to be late. One person said, "If they have been held up they don't usually let me know that they will be late. I have to pick up the phone and ask." A staff member said that sometimes they were late for unavoidable reasons such as traffic. They said the office did not always let people know when they were running late, despite the staff asking for the message to be passed on.

The registered manager told us there was enough staff employed to meet the needs of the people who used the service. They worked this out by looking at the amount of support hours they were contracted to deliver to people, against the amount of hour's staff were employed to work. Staff felt that there were enough of them to meet people's needs. One staff member said, "You always want more staff but there are enough when everyone is in." The registered manager said they were always looking to recruit additional suitable staff to ensure there are enough to cover shifts when required.

People told us they felt safe. One person said, "I trust them." Staff told us they knew how to recognise and report abuse. One staff member said, "Adult protection is part of my job. I've reported concerns to on-call before and it's been dealt with." We saw that concerns were reported to the registered manager and to the local authority when required. This was in line with local safeguarding adult's procedures.

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) sets out requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. Some people who used the service did not have the mental capacity to make certain decisions for themselves. We saw that mental capacity assessments were completed but these were not always decision specific and therefore did not comply with the principles of the MCA. For example, it was recorded that one person 'lacked capacity'. There was no guidance on how staff should support the person to be involved in decision making or evidence that they had been supported to understand information. One person had two mental capacity assessments in their care file. The first assessment stated that they lacked capacity to make their own decisions, yet the person had signed a consent form on the same date. The second capacity assessment stated that the person was able to make their own decisions. This showed a lack of understanding of how the act is used to protect people's rights.

When people lacked capacity to make decisions, it was not clear how decisions were made in their best interests. A number of people were identified as having Attorneys who act on their behalf. However, the agency had not obtained copies of legal documentation to confirm that these attorneys were correct or for what decisions the attorneys had the legal power to make. Not all staff understood the key requirements of the MCA despite attending training. We saw that the registered manager had recently issued a memo to staff outlining how the MCA affects people who used the service. However, not all staff could demonstrate how they supported people to make decisions and how decisions were made for people who lacked the capacity to do so for themselves.

People with complex needs in relation to eating and drinking were not always sufficiently assessed and monitored. For example one person's care plan stated they needed a pureed diet and assistance with eating. However, the daily records did not indicate that a pureed diet or assistance was given. One staff member told us this person needed a thickener in their drinks which was in line with their care plan. Though staff knew they were at risk of choking, they were unsure about the consistency of their specialist diet. The care plan stated that food and fluid records should be kept. Food and fluid records were not being completed for this person. This concern was discussed with the registered manager who said they would address this immediately.

We saw that staff monitored people's health needs and any concerns were reported to the registered manager or the on call managers in their absence. We saw that concerns with people's health and wellbeing were reported to the local authority by the registered manager. A social care professional said, "They're very prompt at getting in touch with any issues and they are very proactive in seeking support."

People told us they thought that staff were well trained and understood their roles. Staff told us and records showed that staff had received induction training when they joined the service, which included shadowing an experienced staff member. One person confirmed this by telling us that a new staff member came to their house with an experienced staff member to help them understand their role. A staff member said, "The induction gives you all the tools you need to do the job, there is nothing not included." A senior staff member said, "A new starter would always shadow an experienced carer and that carer would give all the background information and involve the new starter in ancillary tasks so they are not just standing and looking at the person, because that would be rude." We saw staff were supported to achieve a nationally recognised qualification in health and social care and staff told us this helped them to understand their role in supporting people. One staff member said, "The training is good, some of it is basic but it covers everything."

One staff member told us that the medication training did not include information on hand writing MAR charts, which was the practice adopted by the service. The registered manager told us and we saw records that showed that a new provider for medication training had been sourced and staff were being enrolled on this new course.

The registered manager told us and we saw records that showed staff had supervision. The frequency of this was determined by the manager who assessed which staff required additional support. Staff said that supervision was useful to them. One staff member said, "The manager always keeps me informed and I have supervision to make sure I'm up to date." We saw records that showed additional 'coaching' had been given to staff in certain topics where the manager had deemed this necessary.

Good

Is the service caring?

Our findings

People told us they were treated with kindness and that staff were friendly towards them. One person said, “You couldn’t have two nicer girls.” Another person said “They are lovely. They have a laugh with you.” People felt they had good relationships with their regular staff and felt that staff had made an effort to get to know them. One person described their regular staff member as “talkative” and “a chatterbox” and they liked this.

Staff told us they knew people well and knew their preferences as they had got to know them when providing support to them. One staff member said, “I have good relationships with the people I support. I know them well because we have set runs now, so that is helping people to get continuity.” Another staff member said, “I take a person centred approach to supporting people. Each person is different and they all have different abilities and preferences.”

Some people said that staff listened to them and involved them in their care. However, some people said that staff often appeared in a hurry. One person said, “They are so rushed off their feet at night. They haven’t got time to talk.” Another person who received support from two staff at each visit said that one of the staff would always rush them, whilst the other staff member would tell them not to. They said this made them feel “uncomfortable.”

People told us their privacy and dignity was respected. People said that staff listened to what they said and took note of any special instructions. For example, one staff member pulled back the curtains to let light in, but the person didn’t want them open, so she agreed not to do this again. Staff we spoke with understood how to respect people’s dignity and gave examples of how they do this when supporting people. One staff member said, “I always talk to people and involve them. I ask them if they want privacy and respect this as long as it’s safe.”

People told us that staff encouraged them to be independent. One person said the staff encouraged them to wash themselves because they were able to do this with minimal support. One staff member said, “I prompt people, try to keep them active.” Another staff member said, “I give them time, that time you spend with them each day is important, sometimes we are the only people they see.”

Requires improvement

Is the service responsive?

Our findings

People told us the service was not proactive in ensuring the care they received was personal to them. One relative said, "They wait for you to have an issue." We saw that people were involved in the development of their care plan, alongside the local authority. However, we found that some people's care plans had not been reviewed to ensure that their care still met their needs and preferences.

Care plans were not specific to ensure individual needs were met. For example, some people were identified as being at risk of developing pressure areas. These people did not have specific plans in place to identify the measures taken to reduce the risk of pressure areas developing. We saw that one person's care plan advised staff to 'monitor pressure areas'. There was no detail to explain whether other professionals were involved in managing the risk or what actions were being taken. Although staff told us they monitored pressure areas, there was no recording system to show what had been done. Information about pressure area monitoring was not included in their daily notes. The registered manager told us that they would be updating their recording of pressure area care but they were waiting for guidance from the local authority on which documentation to use.

We saw that care plans were focussed on tasks and did not reflect how people would like to receive their support. Care plans did not always record people's views and preferences. The registered manager told us they were working on reviewing people's care plans to make them more personalised to each individual.

People told us that their preferences in relation to gender of staff supporting them, was mostly adhered to. One person said, "I won't allow a gentlemen to give me a shower" and the agency had supported this preference. However, one person said that they had been upset to find a male staff member arrive in their home when they requested female support only. The person reported this to the office who assured them it would not happen again and it did not happen again.

People told us they knew how to raise a complaint. One person said "I'm not afraid to tell them if I'm not happy." Another person said they had complained about an incident and they received a letter of apology from the manager about the incident. Staff told us they knew how to respond if they received a complaint. One staff member said, "I would listen to them but not make false promises. I would tell them that I would pass on the concerns to the manager who would get back to them. I would also tell them that they could contact social services or the CQC if they weren't happy with the response." We saw that a complaints procedure was in place and that complaints had been responded to in a timely manner.

Questionnaires were sent to people to ask for their feedback and some people told us they had completed these. The registered manager told us they did not receive a high response as many people were unable to complete questionnaires. The service now completes telephone surveys with people who use the service to encourage people to give feedback. We saw that concerns raised via this process were reviewed and addressed by the registered manager. For example, we saw that some people said they did not know who to contact if they were unhappy about the service they received. We saw that the registered manager sent a letter to people who use the service to introduce themselves and also asked staff to inform people of this. We saw the registered manager had also introduced a weekly 'drop in' for people and/or their relatives to speak to them in person about the service they received. We saw that people had used this opportunity for discussion with the manager and that the manager had requested the local authority review some packages of care to ensure they were suitable for people's needs.

Requires improvement

Is the service well-led?

Our findings

There was a lack of management oversight into staff backgrounds. We identified examples where staff were not suitable to work alone with people in their homes without an appropriate risk assessment. Assessments of risk had not been completed and the plans in place were not being followed. The registered manager was unaware of the risks and the plans in place. There were staff employed who were responsible for employment matters and staff who were responsible for completing rotas. These staff were not aware or had not communicated concerns to the registered manager to allow them to assess and manage the risks. There had not been a thorough hand over from previous managers or oversight by the provider. Audits of staff files and staff supervision had not identified this issue. This meant there was a risk that people were not protected from the risk of harm.

Medication records (MAR) were not fully completed to ensure a complete and accurate record of care delivered to people who used the service. For example, people's full names and the date was not always recorded so there was a risk that information could be lost or confused when removed from the person's home. We also saw that there were gaps in MAR charts and no explanation of the reasons for these gaps was recorded. People told us they received their medicines when they needed them but records did not clearly show whether the medicines were given as prescribed. Audits completed by the registered manager identified some issues with medication records including a lack of information about what each medication is for and gaps in recording with no explanation. Additional 'memos' were sent to staff to indicate the importance of accurate recording and this was discussed at a team meeting. However these methods had not been successful as medication records were still not completed accurately. The registered manager told us that additional training in medicines administration had been sourced from a new provider and staff were in the process of enrolling on the additional training.

These issues demonstrated a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people felt that the communication from the service was not effective. People expected to have a rota to show them which staff would be visiting each week and what time they would be arriving. A number of people said that the rota is often late in arriving. One person said they had to telephone the service to find out who would be supporting them and when. The person said this was, "unsettling." One person said, "Sometimes the rota doesn't come. It usually does eventually." Another person said, "The rota is often not right. It changes at the last minute to fit someone else in."

Staff told us they felt supported by the registered manager. One staff member said, "The support from management is second to none. You're not left to flounder." Another staff member said, "The new manager is the best one we've had. They're organised, proactive and implementing good practice." We saw that changes had been made to the way the service was managed and that improvement work was continuing. For example, we saw that the registered manager had completed audits including staff files, care files and medication. A large number of actions had been identified including the incorrect completion of some mental capacity assessments. However, some issues had not been identified and some issues continued despite actions plans being in place. Some actions had successfully been completed and timescales were set for additional improvements.

We saw that staff meetings took place. The records showed that issues had been discussed including medication administration and recording and professionalism. The registered manager encouraged people to attend additional training and had sourced a new training provider in relation to medication, as they had identified that practice needed improvement in this area.

We saw and staff told us that the manager was working to improve the culture of the service. Staff told us they were aware of whistleblowing procedures and said they would use them if they needed to. One staff member said, "Absolutely I would."

The registered manager understood their responsibilities and registration requirements and we had been notified of significant events where required.

Quality monitoring systems were in place. The providers audit systems had identified many but not all of the issues that were found at the inspection. The registered manager was aware of the key challenges facing the service and whilst improvements had been made in many areas, they were aware that improvements were still required and

Requires improvement

Is the service well-led?

were working towards actions identified. We saw actions plans that identified what improvements were needed and when these would be made. For example, an action plan identified further improvements needed to care files to help improve the safety and quality of the service provided.

The registered manager noted that improvements were needed to ensure that risk and needs assessments were up to date before further work on improving the quality and personalisation of the service could take place.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not always use systems or processes which ensured the proper assessment, monitoring and improvement of the quality and safety of the service provided, including the management of risks to people and the keeping of accurate, complete and contemporaneous records in respect of each service user.