Absolute Care Services Ltd

Absolute Care Services (Richmond) Ltd

Inspection report

4 Latimer Road
Teddington
Middlesex
TW11 8QA

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05 February 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Absolute Care Services on 5 February 2018. This was an announced inspection. We gave the service 48 hours' notice of the inspection visit because the registered manager was often out of the office supporting staff or providing care. We needed to be sure that they, or a delegated representative, would be in.

Absolute Care Services is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It was providing a service ranging from personal care to domestic help to 121 people over the age of 18 at the time of this inspection. Not everyone using Absolute Care Services receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the previous inspection in December 2015 we found the service was meeting the required standards. At this inspection the service continued to meet the standards.

A registered manager was 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.

People and their relatives told us that they found staff to be kind, respectful and caring. They told us that the service provided was of high quality and personalised to people's individual needs. The service asked people about the care they wanted and involved them in making day to day decisions about the support being provided, helping them remain independent where appropriate.

People and their relatives told us that staff were punctual and communicated well with them. However, some people told us that there were times when staff were late or that they did not take enough care when tidying up after carrying out their role. The management team recorded this feedback and took action to follow particular concerns up. There were systems to safeguard people from abuse. Staff completed safeguarding training and knew how to report any concerns.

People were supported by staff who were trained and well supported in their various roles. Staff members had been safely recruited and had received an induction to the service.

Staff had access to personal protective equipment (PPE) for the prevention and control of infection.

Staff had received training in the Mental Capacity Act (MCA) and understood the importance of gaining people's consent before assisting them.

The service completed assessments of people's needs and these were used to inform the care plan for each person. The service kept people's needs under review and made changes as required.

People and their relatives felt able to raise any concerns or complaints. There was a procedure in place for people to follow if they wanted to raise any issues.

The service promoted a culture that was person centred, open and inclusive and had systems in place to monitor the quality of the service and the experience of people who used it.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Systems were in place to ensure that people who used the service were protected from the risk of abuse. Staff were aware of procedures to follow to safeguard people from abuse and people told us that they felt safe. Risk assessments were carried out before providing a service to people.

The agency employed sufficient staff to meet the identified needs of the people they provided services to. The service carried out appropriate checks to ensure suitable staff were employed.

Medicines were safely administered by staff and accurately recorded. Staff had been trained in administering medicines and audits were carried out regularly.

Is the service effective?

Good

The service was effective.

Staff had completed training to provide effective care and support to people using the service and received supervision and support from senior staff.

The provider worked within the principles of the Mental Capacity Act 2005 and made sure they obtained people's consent to the care and support they received.

People were supported to stay healthy and well. The service made appropriate and timely referrals to other relevant health professionals when required.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and respected and promoted their privacy, dignity and independence.

The service consulted people and their relatives about the care and support provided and involved them in decision making.

Is the service responsive?

Good

The service was responsive.

People using the service received care and support that was personalised and responsive to their needs.

The provider had systems to respond to complaints they received. People using the service and their relatives felt able to raise any concerns or complaints.

Is the service well-led?

Good

The service was well-led.

The service promoted a culture that was person centred, open and inclusive and had systems in place to monitor the quality of the service and the experience of people who used it.

People told us that they received calls and visits from managers to ask them about their experience of using the service.

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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.

We gave the service 48 hours' notice of the inspection visit because the registered manager was often out of the office supporting staff or providing care. We needed to be sure that they, or a delegated representative, would be in.

We inspected the service on 5 February 2018. One inspector carried out the inspection.

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 information we held about the provider, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We spoke on the telephone with six people who used the service to gather their views about the service provided. We also spoke with two care staff, the area training manager, two supervisors, the service coordinator and the operations director about the work they did and to gather their views of the service.

We reviewed a range of documents and records including; five care records for people who used the service, five records of staff employed by the service, as well as a sample of complaints and compliments records and policies and procedures kept by the service.

Good

Is the service safe?

Our findings

People using the service said they felt safe in the care of the staff who supported them and that their home environment and property was respected by staff. One person told us that they were "very happy", whilst another said that they "had no complaints whatsoever".

People were kept safe and protected from neglect, abuse and discrimination. The service had clear policies and procedures on safeguarding for managers and staff to follow if required. Staff had received training to give them an understanding of abuse and knew what to do to make sure that people using the service were protected.

We looked at training records and staff confirmed they had completed training in safeguarding adults and said they would approach the registered manager if they had any concerns. One staff member said, "I can always get support from the Care Co-Ordinator.". People had care plans which included risk assessments and gave staff guidance on the action to take to protect people from harm. One relative said, "The carers are good and know what we need. They come twice a day and are very good. I have a number to call if I have any problems."

Risk assessments were reviewed regularly to ensure people continued to be safe and staff were able to meet their needs. Records showed risk assessments which had been updated and others had review dates set.

The service had a thorough recruitment and selection process in place for new staff. This helped to ensure people were protected from the risk of receiving care from unsuitable staff. Staff files showed that relevant checks had been carried out before staff started to work for the service. These included obtaining written references, proof of identity, and a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on prospective staff to help employers make safer recruitment decisions.

Newly recruited staff did not work unsupervised until they had completed mandatory training and had been assessed as being competent to work safely with people.

All staff were issued with a handbook prior to commencing their role. This provided employment information as well as policies and procedures which supported staff to keep service users safe, such as safeguarding, medication and emergency policies.

The service managed the control and prevention of infection. Staff received infection control training and told us they were provided with appropriate Personal Protective Equipment (PPE) such as disposable gloves and aprons. This meant staff were protected from potential infection when delivering personal care.

Staff had received training in the administration of medicines and were aware of their responsibility in this area. Policies and procedures were available for staff to refer to and medicines administration records (MAR) were audited monthly.

The registered manager had a system to record any incidents and accidents and a procedure to investigate these. Investigations included speaking with the person in their home and amending the plan of care and risk assessment where necessary.

The service respected equality and diversity. Equality and diversity policies and procedures gave clear guidance to staff to help make sure people's rights and diverse needs were respected. Care staff completed online training and had a good understanding of how to protect people from discrimination and harassment.

Good

Is the service effective?

Our findings

Staff had the right skills and knowledge to carry out their roles. People told us that they were happy that care staff understood what they had to do and that they did it well. Several people told us that although he care was good, sometimes the care staff were not very tidy or good at leaving things as they found it. For example one relative commented, "The actual care is good, but they leave clothes on the floor on a heap and I have trouble then in picking them up. They should fold them and hang them, or put them by the laundry." Another relative said, "Yes, the care is good. But it's the little things, like remembering to put in a hearing aid, or picking clothes up from the floor." We fed this information back to the operations director who put in place an action plan to follow these issues up with the people concerned.

Care staff undertook induction training that was overseen by the area Training Manager. Training was in line with the requirements of the Care Certificate. The Care Certificate is an identified set of 15 standards that health and social care workers adhere to in their daily working life.

Mandatory training was completed both via e-learning and in classroom based sessions. Training included privacy and dignity, dementia awareness, infection control, health and safety and manual handling. The area training manager was able to describe how the service monitored training and kept it up to date. One care staff worker spoke positively about the training received and was able to describe training which went beyond the minimum mandatory training that was provided.

Staff said they felt supported by the management team and colleagues. One staff member commented, "I love this job. I have great colleagues and always have the Care Coordinator to talk to if I need to." Another care staff told us, "I love it here. There's great training and support."

We saw that staff received individual supervision and support. This consisted of personal super vision meetings once every two months, together with management spot checks or telephone interviews every two months. There was an appraisal system in place for all staff.

Support plans included details of any support people needed with their nutrition and hydration and we saw staff recorded this in people's daily care notes. Where required, people's care plans included their religious or cultural dietary needs, for example if a person required a particular diet.

Outcomes were reviewed and changed as necessary. For example, one person's outcome was to maintain nutrition and personal hygiene which had been achieved with regular visits and support. A review showed that a fresh outcome was identified to gain confidence for social inclusion at a day centre once a week.

The provider worked with the local authority to make sure they identified and met people's care and support needs. Some people using the service were referred by the local authority and their care records included an assessment of their care needs and a suggested package of care.

The care co-ordinator told us the service monitored people's health and would report any changes to the

family, GP and social worker as required.

We raised the subject of people's experience with care staff with the operations director and the care co-ordinator as an area for further investigation and review by the service. We saw that they recorded details of people's views as expressed to CQC and put in place an action plan to carry out their own visits and reviews with the aim of monitoring the general tidiness of care staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who use the service and 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. We checked whether the service was working within the principles of the (MCA) 2005.

People told us they were able to make choices about the day to day care they received. One relative told us, "The carers come and ask what needs done. I have no problems."

Staff had received training in understanding their responsibilities under the Mental Capacity Act (MCA). Staff told us they asked people for their consent before delivering care or treatment and respected people's decision if they refused support.

Where people lacked capacity to make some decisions, we saw the provider worked with their relatives or representatives and the local authority to agree decisions that were in the person's best interests.

Good

Is the service caring?

Our findings

People using the service told us their privacy and dignity was respected and that they were treated with kindness. People were consistently positive about the caring attitude of the staff, with comments such as "Very happy with the carers" and "Can't think of anything I'd like to improve."

As part of staff training staff participated in discussions encouraged to share knowledge and life experiences in relation to providing personal support and how individuals would feel receiving this type of support.

The operations director described how the service worked to promote service user networks which included health care professionals, advocates, families, friends and volunteer groups. The service also supported people who had no one else involved in their care, for example by supporting them in booking appointment and transport to hospital. Another example provided was that the service sought consent from relatives to carry out a shopping visit if it was noticed that food was short in a person's home.

People told us they had received information about the care they were to receive and how the service operated. They also confirmed that, in the main, the same group of care staff cared for them, providing a good sense of continuity of care as well as the reassurance that people were being cared for by people who knew them well.

People were involved in making decisions about the support they received. Care plans were regularly reviewed and helped the service support people in their daily life as well as keeping their independence.

Care plans involved people, their families and external professionals such as social work teams, where required. We saw that care plans contained updated risk assessments, were signed by people and had review dates.

We discussed with the operations director and the care co-ordinator how some care plans contained little detail and in one case appeared to be simply copied from the previous care plan review. They immediately took these files aside and confirmed they would investigate this.

People's privacy and dignity was respected and these topics formed part of staff training. Staff asked people's permission before carrying out any tasks and consulted them with regard to their support requirements. Staff were aware of the requirement to maintain confidentiality and the need to ensure that personal information was not shared inappropriately.

In the previous 12 months there had been four care staff who were recognised for their contribution and one winner in the London Borough of Richmond-upon-Thames Dignity in Care Award.

Good

Is the service responsive?

Our findings

People were confident that they received personalised care that was responsive to their needs. Interviews with staff demonstrated that there was a commitment to providing an individualised care service to people.

Area Supervisors were responsible for a particular geographical region. They worked with people and care staff within that zone to manage the service and schedule the visits. This reassured people that when they contacted the service they had a person that was familiar with their needs, choice of support workers and visit times and who could respond to queries in a timely fashion.

People were able to contribute to the planning of the care and support they received. Before they started to provide support to people, a senior staff member visited them to complete an assessment of their needs and get their feedback about the support they required. Where care was commissioned by the local authority, records also included a supplied assessment and care plan. A care plan was then written based on a person's individual needs.

Records showed the service regularly reviewed people's care plans to make sure they had up to date information about their support needs. Records included evidence of regular spot checks by senior staff including of the care documentation in place at the person's home. Telephone calls were also made to people on a rotational basis to regularly ask them how they felt their care plan was helping them.

Daily care records were completed by staff at the end of each visit. These recorded a summary of the care and support provided including the person's mood and information about any changes in care needs.

Care staff told us the service gave them information about people's care and support needs before they visited them for the first time. Technology was used in providing the service, for example by an electronic signing in and signing out system. This allowed the service to track and monitor when visits were being attended and allowed the service to be responsive to any delays and act accordingly.

People told us they knew how to make a complaint and the provider had a system and process to respond to complaints. We saw that concerns and complaints had been appropriately logged and responded to. For example, one complaint was resolved through discussing with relatives and the individual concerned who would be able to authorise changes in the number of care hours that were required. Another complaint was resolved by the service writing to the person acknowledging where there were shortfalls in the service and what action they would take to resolve this.

We also saw examples where people or their relatives had written to the service praising them for the quality of their care and complimenting their staff. In the 12 months leading up to this inspection the service had received three complaints and 13 letters of compliment.

Good

Is the service well-led?

Our findings

People and their relatives told us the service was well led. They consistently reported that they were happy with the care and support provided by the service. One person commented, "They are great. I can always talk to the manager." A relative told us, "I know the girls from the office sometimes visit and call us. I would give them 8 out of 10. Apart from sometimes being late and a bit untidy they are a good service."

Staff told us they felt respected, valued and supported by the registered manager and other senior staff. One staff member said, "I love working here. I have great colleagues and can always speak to the manager."

A registered manager was in post who was responsible for the day-to-day running of the service. 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 and associated Regulations about how the service is run.

It became clear during the inspection that when staff referred to "the manager", they did not mean the registered manager but the care co-ordinator. Staff told us that they felt able to discuss anything with the care co-ordinator, but told us they would appreciate a more visible presence from the registered manager, whom they felt they did not know very well.

We discussed this with the operations director and requested that the management team reflect on this and consider whether the current registered manager was able to fully fulfil the role of being responsible for the day-to-day running of the service and to work towards improving the service as the requirement for registered manager demands.

However, within the service branch itself there was a clear leadership structure in place. The registered manager was supported by a care coordinator and area supervisors who managed and supported care staff. Feedback was obtained from people through care review meetings and spot checks of individual staff carrying out their duties. In the 12 months leading up to inspection there had been 124 quality assurance visits made to people's homes to monitor the quality of care provided.

The service also sought feedback from people and their relatives regarding their experience of receiving care. In addition to spot check visits, telephone calls and the use of compliment and complaints processes, the service also carried out an annual survey.

We saw that the service had received feedback via surveys. We discussed that there was room for the service to demonstrate greater evidence that they translated the data and information the service received via surveys into a quality analysis with action plan. We also recommended that the manager explore ways of connecting the feedback from surveys with feedback from other sources – for example phone calls, complaints and spot checks – in order to achieve a wider and more comprehensive picture of people's experience.

The service worked in a collaborative and open way with external stakeholders and agencies to support the care provision. We saw evidence of the service communicating with other involved healthcare professionals to help ensure joined-up care. For example, with social services and healthcare agencies.

In addition the service maintained good links with social services, provider forums and organisations related to the field of domiciliary care, dementia and professional development, such as Skills for Care and local provider forums.

There were systems in place to ensure the security of confidential information.