Asalina Live In Care Services Ltd

NORTHAMPTON

Inspection report

60 Northwood Road
Abington
Northampton
Northamptonshire
NN3 2LR

Tel: 01604459567
Website: www.asalinacare.co.uk

Date of inspection visit:
09 February 2017
14 February 2017
16 February 2017

Date of publication:
23 March 2017

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

Summary of findings

Overall summary

This inspection took place on 9 and 16 February 2017 and was announced. Asalina Live in Care Services provides personal care for people living in their own homes. At the time of our inspection there were 3 people receiving personal care.

The was a registered manager in post who was also the provider. 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.

Risks to people had not always been assessed and plans of care had not been developed to provide direction for staff in how to mitigate the risks to people. However, staff knew people well and had adjusted the care that they provided to people in manage the risks to them.

People could not be assured that they would receive their medicines safely. Staff had not received training the safe administration of medicines and the records pertaining to the medicines that staff should administer were not always accurate.

The provider had not considered the competencies and skills of the staff providing care to people. Staff did not have access to regular or appropriate training and did not have the skills that they required to provide care safely.

Staff did not have access to formal supervision to provide them with effective support and professional development.

Quality assurance systems had not been developed or implemented by the provider which had resulted in the shortfalls that we identified during this inspection failing to be identified or addressed.

People's health and well-being was monitored by staff and they were supported to access relevant health professionals in a timely manner when they needed to. People were supported to have sufficient amounts to eat and drink to help maintain their health and well-being.

People received care and support from staff that knew them well. Staff provided people with dignified care and support in line with their preferences.

The registered manager was a visible role model in the service and motivated staff to provide person centred, quality care and support.

At this inspection we found the service to be in breach of three regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this

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.

Risks to people had not always been assessed although staff had adapted the care they provided to people to mitigate risks to them.

People could not be assured that they would receive their medicines safely.

People received their care at their preferred times from staff who knew them well.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have access to formal supervision to support them in working effectively in their role.

Staff had not received training in key areas that they required to provide care safely.

People were actively involved in decisions about their care and support needs and how they spent their day. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA).

People were supported to access relevant health and social care professionals to ensure they received the care, support and treatment that they needed.

Is the service caring?

Good

The service was caring.

People were supported by consistent staff that they knew and had developed positive relationships with.

People were encouraged to make decisions about how their care was provided and their privacy and dignity were protected and promoted.

People were listened to, their views were acknowledged and acted upon and care and support was delivered in the way that people chose and preferred.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's plans of care were not sufficiently detailed or personalised to guide staff in providing consistent care and support.

People were listened to, their views were acknowledged and acted upon and care and support was delivered in the way that people chose and preferred.

.

People knew how to raise a concern or make a complaint and a system for managing complaints was in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance systems had not been developed to identify and address shortfalls in the service.

The provider who was also the registered manager was visible and accessible to people and staff.

The provider was committed to providing people with quality, personalised care and support and to addressing the shortfalls that we found during this inspection.

NORTHAMPTON

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 9 and 16 February 2017. The inspection was announced and was undertaken by one inspector. . The provider was given 24 hours' notice because the location provides care for people in their own homes; we needed to be sure that staff would be available to support the inspection.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law.

During this inspection we met two people receiving care from Asalina Live in Care and spoke with two relatives of people receiving care from the service. We also looked at care records and charts relating to three people. We spoke with two members of staff, including the provider. We also spoke with people who commissioned care from Asalina Live in Care Services and looked at two records in relation to staff recruitment and training, as well as records related to the quality monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

Risks to people had not been assessed and people could not be assured that staff would provide the care that they needed to manage risks to their health and welfare. The provider did not have sufficient systems in place to assess the risks to people or implement guidance for staff to follow in order to mitigate these risks. Although people received care from staff that were knowledgeable about providing care and had adapted the care they provided to meet people's needs there were no reliable systems in place to formally assess people's risks. For example staff told us that one person was at risk of developing areas of sore skin due to friction between their limbs. This person did not have a care plan in place to guide staff in managing their pressure areas or a risk assessment to show they were at risk of developing pressure areas. Staff told us that they ensured barrier cream was applied to mitigate the risk of this persons skin integrity breaking down. This person told us "The staff always help me dry my legs and put my creams on." Staff told us that another person had a diagnosis of epilepsy and had regular seizures requiring the administration of rescue medication. This person did not have any form of care plan or risk assessment to provide staff with direction on how to support them in the event that they had a seizure or to maintain their safety.

The failure to implement a system to regularly assess people's risks and to ensure that adequate and consistent control measures and guidance for staff was implemented constituted a breach of regulation. This was a breach of Regulation 12 (1)(a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

People could not be assured that they would receive their prescribed medicines safely. One person using the service was prescribed a medicine that required staff to be trained by a medical practitioner in order to administer it safely. Staff that were providing this person with support and may be required to administer this medicine, had not received the training that they required to do this safely. The provider told us that staff had been required to administer this medicine on a number of occasions to this person. We asked the provider to take immediate action to provide staff with training in how to administer this medicine safely prior to them providing care to this person.

The records in relation to the administration of people's medicines were not accurate and the provider did not understand or implement their own medicines policy consistently. For example, the provider told us that one person they supported managed their own medicines however, we found that staff had been recording the administration of this person's medicines on a Medicine Administration Record (MAR) Chart although they had no involvement in the ordering, storage or administration of this person's medicines. The provider told us that for another person they had no involvement in the administration of their medicines and that this was completed by their family. However this person's relative told us "The staff administer [Persons's Name] night time medicines every day. They always make sure they give them their tablet." We reviewed the MAR chart for this person and found that staff had recorded that the medicine had been administered by their family and not by staff.

This was a breach of Regulation 12 (2)(g) of the HSCA 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

People received their care at their preferred time and there were sufficient numbers of staff to provide people's commissioned care. One person told us "The staff always arrive at about the same time and it's good because there are only a few staff that provide my care so I know them well." Another person told us "The staff always come on time, if they get caught up on another call and run a bit late then they phone to let us know. That rarely happens though."
Staff were knowledgeable about the steps to take if they felt people were at risk. Staff knew how to report concerns about people's safety and felt confident to do so. One member of staff told us "If anyone was ever at risk here I'd report it straight to the manager and the safeguarding adults team."

Appropriate recruitment practices were in place to ensure that staff were of a suitable character to provide people with care and support. Records showed the appropriate checks and references in place. These included two written references, (one being from their previous employer), and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring checks on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

Staff providing care and support did not have the skills and knowledge that they required to care for people safely. One member of staff had not received any training from Asalina Live in Care Services. The provider told us that this person worked as a relief carer and was also employed by another agency that provided them with training. However, the provider did not have any training records for this person and could not be assured that they had received the training that they required to be competent in their role and to provide safe care to people. Another member of staff who had been recently employed by Asalina Live in Care Services had received an 'All in one day' training course covering training in all aspects of providing care. The provider told us that following this training they had assessed this member of staff as being competent in providing care to people. This member of staff had no recent experience in working in a care setting and the training provided to them was not sufficient to ensure that they had the knowledge and competencies that they required to care for people effectively. The provider who was solely responsible for assessing the competence of staff to provide care safely to people had not accessed any form of training whilst employed by Asalina Live in Care Services. The provider told us that Asalina Live in Care Services had not training provider identified to provide training to staff.

The staff providing care to people did not have the skills, competencies or training that they required to do this safely. The provider had ensured that sufficient numbers of staff were employed to provide people's commissioned care however, had not considered the skills and competencies that staff required to provide care safely. For example we found that the provider had deployed staff to provide care before they had receive the training that they required to do this safely.

Systems had not been established to provide staff with formal supervision. The provider who was also the registered manager was solely responsible for providing supervision to staff. They told us that they observed staff when they first started working for Asalina Live in Care Services however, had not provided formal supervision to any member of staff in over 12 months.

This was a breach of Regulation 18 (1) (2) (a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.

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.

The registered manager and staff were aware of their responsibilities under the MCA code of practice. People's care plans contained assessments of people's capacity to make decisions and evidence of best interest decisions if people lacked capacity. On a day to day basis people were encouraged and enabled to make decisions about their care and support. One person told us "The carers always ask me what I want doing when they visit me."

We saw examples in people's care records of staff reacting positively to changes in people's health, contacting their GP and reporting these changes to the on-call staff. Staff were vigilant to people's health and well-being and ensured people were referred promptly to their GP or other health professionals where they appeared to be unwell.

People received the support that they needed to have sufficient food and drink. People's risk of not eating and drinking enough to maintain their health and well-being had been assessed, monitored and managed through their individual plans of care. Staff ensured that people were encouraged to eat and drink regularly. One person told us "The carer's always help me make my breakfast and give it to me so that I can eat it."

Good

Is the service caring?

Our findings

People received support from staff that provided kind and compassionate care. Staff knew the people that they supported well and were motivated to provide consistently personalised care and support. The people we spoke to praised the approach of staff and the positive relationships that they had developed with the staff providing them with care and support. People were supported by the same staff and knew them well. People told us "The carer's are brilliant; so kind. They have a great sense of humour and we have a laugh together." and "The carer's are very nice. Its good having the same people that are kind so you get to know them."

People were supported in a dignified manner in a way that maintained their privacy. One person's relative told us "They help my wife to get washed and dressed but she has to do that in our lounge. They always make sure that they shut the curtains and the doors so it's done in private." Staff were able to provide examples of how they supported people in a dignified manner, such as using positive language to encourage people to be independent, closing curtains when providing personal care and encouraging people to make choices about their activities of daily living.

Staff knew the people they supported well; they were able to tell us about people's interests; their previous life history and family dynamics. One person told us "I know my carers very well. The same people come to see me and we get on great."

People were encouraged to express their views and to make choices on a day to day basis. We observed staff asking people what care they wanted during each call, what meals they would like staff to prepare and whether they need to change the times of planned calls or would like additional care calls. One person told us "I don't know what I would do without the staff. My daughter is going on holiday and they are going to give my wife and I a bit of extra help."

Requires Improvement

Is the service responsive?

Our findings

People were assessed before they received care to determine if the service could meet their needs. These assessments were effective at identifying areas that people required support, however plansof care were not then developed to guide staff in meeting people's assessed needs. The assessments covered all aspects of a person's individual needs, circumstances and requirements. This included details of the personal care required, duties and tasks to be undertaken by care staff, risk assessments, how many calls and at what times in the day or evening.

These assessments provided clear guidance to staff in the area's that people required support however, did not provide personalised guidance to staff in how they should provide this support. For example, one person's care plan stated "[Person] requires help to wash." There was no further guidance for staff to follow in relation to what level of support they should provide to this person for example; prompting or physical assistance to wash. However, people told us that staff knew them well and provided the care that they needed as they were supported by a small and stable team of staff. The provider was aiming to expand and increase the amount of people that it provided care to and there is a risk that as new staff are employed people will receive inconsistent care and support as appropriate personalised guidance for staff in meeting people's care needs had not been developed. As people's needs changed their assesments were not updated. For example, one person who required support to administer creams to mitigate the risk of them developing pressure area's had no plan of care in place to direct staff to do this consistently. The provider told us that they were committed to developing their care planning procedure and introducing more personalised care plans to guide staff in providing care.

People had also been supported to complete a 'one page profile' which provided staff with a brief life history of people using the service and an overview of what was important to them. This was included so that staff knew something about the person's life and interests. Staff were able to describe people's hobbies, interests and previous employment roles and clearly knew people that they supported well.

People said they knew how to complain and felt confident that their concerns would be listened to. There was a complaints policy and procedure in place however, the provider told us that they had not received any complaints. The provider was able to describe how they would utilise their complaints procedure effectively and told us that they were committed to taking feedback from people seriously and resolving any issues that they may raise.

Requires Improvement

Is the service well-led?

Our findings

There was insufficient monitoring of the quality of the service. The provider who was also the registered manager had not developed any form of quality monitoring of the care and support provided to people. This had resulted in the shortfalls that we found in relation to staff training, care plans and medicines failing to be identified or addressed by the provider. There were no formal systems in place to identify and address shortfalls in the service provided to people. The provider was committed to providing quality care and support to people however, had not developed systems to assure themselves that the care that people received was of a consistently high standard.

This is a breach of Regulation 17 (1) (2) (a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Good Governance.

The provider was visible and accessible to people receiving care and support from Asalina Live in Care Services. People told us that they felt the service was well managed. One person told us "The manager is very good; whenever she visits me she is very helpful and kind." We observed people interacting positively with the provider during this inspection and it was evident that people felt confident in the provider's presence and knew them well.

Staff told us that they felt well supported and that the provider was accessible and responsive to their feedback. One member of staff told us "If you need to talk to [Provider] you can call at any time. I feel well supported and think that the company is well managed."

The provider was committed to providing people with quality care and support in line with their individual preferences and reacted to people's feedback swiftly. For example, if people reported that they felt unwell or required additional care calls the provider ensured that additional support was provided. Where people had been admitted to hospital the provider ensured that staff continued to visit them to maintain contact and provide emotional support. The provider acknowledged that they wished to expand the care and support provided by Asalina Live in Care and was actively seeking new packages of care; but told us that they would prioritise the improvements that were required within the service prior to providing care to new referrals. The Local Authority told us that they would be providing support to the provider to enable them to implement improvements in the areas that we found during this inspection.

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 12 HSCA RA Regulations 2014 Safe care and treatment People could not be assured that their medicines would be managed safely. This was a breach of Regulation 12 (2)(g) of the HSCA 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment. The failure to implement a system to regularly assess people's risks and to ensure that adequate and consistent control measures and guidance for staff was implemented constituted a breach of regulation. This was a breach of Regulation 12 (1)(a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was insufficient monitoring of the quality of the service. The provider who was also the registered manager had not developed any form of quality monitoring of the care and support provided to people. This is a breach of Regulation 17 (1) (2) (a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Good Governance.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Systems had not been established to provide staff with formal supervision. The staff

providing care to people did not have the skills, competencies or training that they required to do this safely. This was a breach of Regulation 18 (1) (2) (a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.