Agincare UK Limited

Agincare UK New Milton

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

Agincare New Milton is a domiciliary Care Service and is registered to provide personal care and support to people in their own homes, in and around New Milton and the surrounding areas. The service also provides a React service, which provides short term support for people once they return home form hospital.

There was not a registered manager in post at the time of our inspection, although an application had been made by the area manager as an interim arrangement until the new manager was ready to register with the commission. 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.

This inspection took place on 9, 13 November 2015 and we carried out home visits to people receiving care on 20 November 2015. The provider was given short notice of the inspection as we needed to be sure that people would be available when we arrived.

We had received a number of concerns about Agincare New Milton during the summer of 2015. The local authority had changed the way it contracted care to people in their own homes and the service had been required to take on additional care packages as part of the new contract. This had led to a significant increase in care visits and the service lacked the staffing resources to provide the care safely. Senior managers at Agincare took the decision not to take on any more care packages until they could resolve the difficulties they were experiencing, so as not to increase risks to people. During this time, people and relatives had contacted us because they had felt neglected at times due to late or missed calls. We worked closely with the local authority safeguarding team to monitor the situation and brought our inspection forward to check that people were safe.

We found the provider had a new manager in place and improvements were being made.

The provider had systems in place to respond to and manage safeguarding concerns and make sure that safeguarding alerts were raised with other agencies.

People and relatives said that they felt safe with the care staff who visited them and if they had any concerns they were confident these would be quickly addressed by the new manager.

People's needs were fully assessed with them before they started to receive care to make sure that the service could meet their needs. People were involved in planning their care. The new manager was in the process reviewing each person's care with them and their family members. Some care plans had been updated and this was a work in progress.

People had risk assessments in place to identify risks that were relevant to them. Staff were aware of

people's individual risks and arrangements were in place to manage these safely. Staff knew each person well and had a good knowledge of their needs.

There were sufficient numbers of qualified, skilled and experienced staff deployed to meet the needs of people most of the time. However, some people, relatives and staff told us there was not always enough time and they felt rushed. The new manager was still recruiting more staff to ensure they could meet the requirements of their React contract with the local authority. The provider operated safe and effective recruitment procedures.

People and relatives currently managed their own ordering, storage and disposal of their medicines. Staff did not currently administer medicines but prompted people when required and recorded when people had taken their medicines. Clear and accurate records were not always maintained in relation to applying creams.

Staff received supervision and competency assessments providing them with appropriate support to carry out their roles. Appraisals had not been completed although this was in hand. Training records showed that staff had completed training in a range of areas that reflected their job role and this was on-going.

Where people lacked the mental capacity to make decisions the service was guided by the principles of the Mental Capacity Act (MCA) 2005 to ensure any decisions were made in the person's best interests. However, staff had not yet received training in this area and some staff lacked knowledge about the MCA.

People and relatives currently managed their own food shopping and meal choices. Staff provided support to cook a meal for people where this had been identified as a need. People's food and drink intake were monitored when they had been assessed as being at risk of malnutrition or dehydration.

People were treated with kindness. Staff were patient and encouraged people to do what they could for themselves, whilst allowing people time for the support they needed. Staff encouraged people to make their own choices and promoted their independence.

People knew who to talk to if they had a complaint. Complaints were passed on to the new manager and recorded to make sure prompt action was taken and lessons were learned which led to improvement in the service.

People spoke positively about the way the service was now being run. The new manager and staff understood their respective roles and responsibilities. The new manager was approachable and understanding to both the people they supported and staff.

There were effective systems in place to monitor and improve the quality of the service provided. We saw that various audits had been undertaken and improvements to the service were on-going. However, some records were not always accurate or up to date.

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.

There were sufficient staff deployed to meet people's needs most of the time, although sometimes people and staff felt rushed. Staff recruitment was robust and ensured only those people who were suitable to work with adults at risk were employed.

People told us they felt safe and were treated well by staff. Staff understood their responsibilities for keeping people safe and knew how to recognise abuse and keep people safe from harm.

Is the service effective?

Requires Improvement

The service was not always effective. Not all staff had received regular supervisions and appraisals. Staff were provided with training and support to ensure they had the necessary skills and knowledge to meet people's needs.

People's rights were protected under the Mental Capacity Act 2005 (MCA) and best interest decisions made under the Deprivation of Liberty Safeguards (DoLS). However, not all staff had received training and lacked knowledge of the MCA.

People managed their own shopping and meal choices but were supported by staff to cook their food where required.

Is the service caring?

Good

The service was caring. The new manager and staff demonstrated caring, kind and compassionate attitudes towards people and relatives.

People's privacy was valued and staff ensured their dignity at all times.

People were included in making decisions about their care. Staff were knowledgeable about the support people required and how they wanted their care to be provided.

Is the service responsive?

Requires Improvement

The service was not always responsive. Complaints were mainly in relation late and missed calls which were responded to in an open, honest and timely manner. The provider had taken steps to improve, although some people told us staff still arrived late on occasions.

People's needs were fully assessed with them before they started to receive a service to make sure their needs could be met.

The management team responded to people's needs quickly and appropriately whenever there were changes in their care and treatment.

Is the service well-led?

Requires Improvement

The service was not always well led. Records relating to people's care were not always accurate or clear.

Most staff, people and relatives were positive about the leadership of the service, said they had noticed improvements in the management of the service and felt supported by the new manager and the provider.

The new manager undertook regular audits to check the quality of the service provided to people and to continuously improve standards.

Agincare UK New Milton

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 13 November 2015 and we visited people at home on 20 November 2015. We carried out this inspection in response to some concerns we had received. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the manager and staff would be available to speak with us.

The inspection team consisted of an inspector, a bank inspector and an expert by experience with knowledge of dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service such as previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law. Following the inspection the provider completed a Provider Information Return (PIR) which had been mislaid during the transition period between managers. We were able to use the information in the PIR to confirm what we had been told at the inspection. The PIR 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.

During our visit we spoke with the new manager, ten care staff, two field care supervisors, eleven people using the service and fifteen relatives. We also spoke with the area manager who had overseen the recent changes within the service. We looked at five people's care plans and medicine administration records (MARs) and pathway tracked three people using the service. This is when we follow a person's experience through the service and view their care records to gain an understanding of the actions staff have taken to ensure safe and effective care is provided. We also looked at four staff recruitment files and nine training records. We viewed other records relating to the management of the home such as complaints and quality assurance systems. Following the inspection we spoke with two social care professionals to gain their views of the service.

We last inspected this service in December 2013 when no concerns were found.

Good

Is the service safe?

Our findings

We spoke with the local authority during our inspection in November 2015. They told us the new manager had been open and responsive to the complaints and concerns that had been raised during the previous few months and had investigated these appropriately. The service was no longer one they had concerns about about as lessons had been learnt and the new manager had also taken action to put safeguarding systems in place to minimise risks to people. This was confirmed by our inspection findings and when we spoke with people and relatives, who told us they felt safe when being supported by the care staff from Agincare New Milton. One person said they "Definitely" felt safe and when asked, relatives told us "Yes. It's safe enough" and "Oh yes. It's safe care." People told us they managed their own medicines but staff prompted or checked that this had been done. For example, one person told us "They [staff] will say to me 'Have you put your eye drops in'?"

People and relatives we spoke with told us they currently managed their own medicines and did not require any support with this. However, each person had a medicines management assessment in their care plan which detailed the support they required, if any, with their medicines. For example, one person's assessment stated 'Understands what their meds are for. They are aware of the day, date and time, directions to take the medicines and remembers to take them'.

The service had systems in place to ensure that where they were providing support with medicines, this was carried out in accordance with prescribed instructions. Staff recorded on a medicine administration chart (MAR) when each person had taken their medicines or had creams applied, or the reason it had not been given, such as if a person refused. We checked a sample of MAR charts and noted there were no gaps in recording. All staff had received medicines training and this was repeated annually, along with spot checks to ensure they were supporting people with their medicines safely.

People were protected from the risk of abuse because staff were fully aware of how to recognise and protect people from abuse. The service responded to and reported safeguarding concerns appropriately and worked closely with the local authority to ensure any concerns were investigated. Staff told us, and records confirmed they had received safeguarding training. Staff were aware of the procedures in place to keep people safe which guided them on how and when to report concerns, telling us they would report any concerns to the new manager immediately. A copy of the guidance for staff was on display in the reception area so staff could have reference to it if they needed to.

There were sufficient staff deployed to meet people's needs most of the time. However, some staff told us they felt rushed at times and did not always have time to do everything. Some people and relatives agreed, telling us that care was sometimes rushed. The new manager told us there had been changes within the staff team due to some staff leaving and new staff being recruited, and recruitment was on-going. During difficult periods, they and other office based care staff had visited people at home and supported them with their care. They had stopped providing the React service due to not having enough staff to cover that aspect of the service as well as the on-going care packages, and had just started to take on a few new care packages for React as they slowly recruited new staff. The React service provided support to people when

they first returned home after a stay in hospital.

People were protected because appropriate recruitment checks were carried out before staff started work. We looked at a sample of four staff recruitment files. The recruitment process included applicants completing a written application form with a full employment history. Checks had been completed before staff worked at the home and these were recorded. The checks included taking up written references, an identification check, and a DBS (Disclosure and Barring Service) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and adults, to help employers make safer recruitment decisions. Face to face interviews had been held. The recruitment process aimed to make sure people were appropriately skilled and suitable to work with people.

Individual risk assessments were in place for each person who received a service. Staff told us that where particular risks were identified, measures were put in place to ensure the risk was safely managed. For example, one person who required turning in bed also had fragile bones and required staff to take a specific approach to minimise the risk of fractures. Staff also explained about the measures they took to ensure they did not spread any infection between people, such as using a fresh apron and gloves for each home visit.

Environmental risk assessments had been completed to ensure both people and staff were aware of risks such as uneven floors or poor lighting. The new manager said it was sometimes not possible to fully address the risks because they could not insist that people made changes to their home, but the risk could be flagged up on the computer to make staff aware. We saw examples of this on people's records. Accidents and incidents were recorded, monitored and addressed appropriately.

Requires Improvement

Is the service effective?

Our findings

People and relatives spoke highly of the care and support provided by staff. One person told us the staff varied and said "They are all very capable and very nice. They are well trained" but went on to say that two staff in particular were "Excellent. Really good." Other comments included "Certainly they [staff] are effective. I feel listened to" and "They [staff] are well trained and polite."

Staff were not fully supported in their role, although this was in the process of being addressed by the new manager. Supervisions and appraisals had not taken place in line with the provider's policy. Staff had not received regular supervisions to support them in their role and identify their learning and development needs, discuss best practice and people's care needs. However the new manager had started to carry out spot checks and competency assessments with staff to monitor their abilities and practice. Staff confirmed this and one member of staff told us "Since [the new manager] came we've had spot checks and assessments. We've had a couple in the last couple of months." The new manager told us that annual appraisals had not yet taken place. However they had given pre-appraisal paperwork to all staff and would be carrying out appraisals in the near future.

Staff told us how they always asked people for consent before providing any care or support and this was confirmed by people and relatives who told us "They talk to my spouse and gain consent" and "The carers do ask for consent, very much so." However, not all care staff understood the Mental Capacity Act 2005 (MCA) and were not able to describe when a best interest decision may be appropriate. There were consent forms in people's files which had been signed by people or relative's to say they consented to their care and treatment. New care plans were being implemented and these now included a consent form as part of the overall care plan.

Records showed that where people lacked capacity this had been properly assessed by senior staff and documented. Where people were unable to express their views or make decisions about their care and treatment, senior staff had involved relatives and other relevant people in making best interest decisions appropriately. People and relatives told us and their care plans showed they were involved in decisions about their care and treatment. Relatives told us they were able to express their views about their family members care and were invited to care reviews.

New staff were required to complete the provider's corporate twelve week induction programme. This involved attending training sessions and shadowing other staff as well as being observed to demonstrate competency in key areas. For example, infection control, moving and handling and dignity, respect and consent. The new manager told us that all staff would go through the competency assessments again so they could assess how they were working. The Care Certificate had been implemented as part of the induction programme. This replaced the Common Induction Standards and National Minimum Training Standards in April 2015. The Care Certificate is an identified set of standards that care staff are required to meet in their day to day care practice.

The new manager kept an over view of staff training. We looked at a sample of twelve staff training records.

Staff training was mostly up to date and relevant to meet the needs of the people. For example, records showed eleven out of twelve staff had received training in safeguarding, and all twelve staff had received training in safe medication, infection control and moving and handling. MCA training had been booked for week beginning 22 November 2015.

Initial assessments had identified where people had a special dietary need or required assistance with eating and drinking and this was recorded. The new manager told us no-one they currently supported had any special dietary needs. If they required help with eating and drinking, this was provided by family members who lived with them. They also told us visits were prioritised on the rotas for people who lived alone and required regular eating times because of health conditions, such as diabetes.

People and relatives confirmed they managed their own shopping and cooking. One person said they had meals delivered and another person said they usually cooked for themselves but their relative had brought their dinner in that day. One person who lived on their own said staff did sometimes help them cook their food. During a visit to this person we observed staff remind them to "drink plenty" and replenished a glass of water on their table top.

Good

Is the service caring?

Our findings

People were complimentary about the staff and told us they treated them well and provided them with the care and support they needed. During our visit we saw positive interaction between staff and people. Staff spoke with people in a friendly and sensitive way. One relative told us, "The staff are excellent. I can't fault them" and "They do it because they enjoy it" and "He is the loveliest young man." One person told us a staff member was "The nicest person I've met. They can't do enough. They're an asset and have such a big beautiful smile." They told us that some staff paid attention to small details such as smoothing out the bed clothes to make it look nice which "Makes all the difference."

People told us they were involved in decisions about their care. Staff took time to listen to people and relatives, involve them in conversation and respected the decisions they made. There were positive relationships between staff and people and relatives. Some people had received support for several years and staff knew them very well. Staff told us they had got to know each person's needs by talking with them and their relatives and reading people's care plans. One member of staff told us about the importance of building a rapport with people and were able to tell us about the people they supported. One relative told us "He [my relative] uses sign language to staff" which they said the staff understood. "He would be lost without them. He's very, very happy with it."

People and relatives told us that care staff were now more consistent. One relative said "We get the same person now generally. The routine is better, easier. It's important." Another relative told us "When it first started we never knew who would be knocking at the door but since [the new manager] started it's been brilliant." They told us how three regular staff now supported their family member. "I don't know how they do what they do." They said the staff were very caring and had told them "We're not just here to look after [your relative] we're here to look after you too."

People's privacy and independence was promoted and respected. We observed staff providing care to people and saw they were kind and respectful. They knocked on the door and called out "Hello" as they entered people's homes.

People were supported to express their views when they received care and staff gave people information and explanations they needed to make choices. One person told us, "It's all very good, they (staff) always ask what they can do to help me". We observed that staff asked people what they wanted them to do and knew how to carry out the tasks requested of them. One person had started to cook their own lunch when the staff arrived. They asked if the person wanted them to finish preparing the lunch, but were told no, and this was respected. They used a wheelchair and were not able to move around too easily due to restricted space in their home. They told us "Once I've washed, [The staff] always go to my bedroom and select different outfits. They stand in the doorway and make sure I can see what they're holding up and say "Do you want to wear this one, or this one? I decide."

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us they were involved in developing their care plans. Comments from relatives included "Staff check things with me all the time" and "They welcome my involvement." However, some people and relatives told us there were still sometimes problems with lateness of calls which could impact on their health and activities. For example, one person got picked up to go to a club and said "If they don't get here before nine I have everyone waiting for me. I feel awful." Another person said they could not get up until staff had assisted them with personal care and they were often late, although most agreed that things had improved since the new manager had started.

People and relatives told us they knew about their care plan and had a copy of it in their home. We saw this to be the case. Records showed people's care plans and risk assessments had not been reviewed regularly, or when people's needs changed. This was now in hand and the new manager had a schedule in place to review each person's care plan and risk assessments which they had written on the white board in the office so they could keep track of whose had been completed and which still needed to be done.

Care plans contained detailed information about each person's health, support and care needs, individual choices and decisions they made about their care and what was important to them. There was also comprehensive written guidance about how to provide people with the care they needed. Staff told us people's needs were monitored on a day to day basis, discussed with the person and any concerns were reported back to the senior staff at the office. People and relatives told us staff made notes each time they visited and these were recorded in their personal file. When asked, most told us they didn't read what had been written but two relatives who had read their notes told us they reflected the care that had been given.

People and relatives confirmed they were involved in the review process. One relative told us "[The new manager and the area manager] came out at the weekend to observe a whole weekend of [my relative's] care, to see what was involved and to explain the process. [The new manager] said bear with me. We discussed the best times for visits, [my relative's] lifestyle," and decided on the staff who would become the regular carers. Another relative told us how staff had worked with them to ensure the care and support their relative received was tailored to meet their individual needs. They told us "The quality of care is so important. [My relative] can't turn herself and they have to be very careful and slow [due to her condition].

The service had a complaints policy and procedure for responding to and managing complaints. People and their relatives told us there had been a period during the summer of 2015 when things had not gone well but most now said things had improved. They now felt confident in raising any concerns or complaints with the new manager if they were unhappy with anything and thought it would be addressed. One relative said "If they don't know there's a problem, they can't do anything about it can they." We looked at the complaints log and saw there had been numerous complaints in previous months and these had been thoroughly investigated and resolved by the new manager and responses sent in a timely manner. The new manager told us, "We know there had been a problem but we've held our hands up and have tried to be open about it and are involving people". The complaints we reviewed confirmed what the new manager had told us.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and healthcare professionals spoke positively about the new manager. They told us that they thought the service had improved recently. One health care professional told us the service was no longer one they were concerned about and that since the new manager had been in post the complaints had tailored off."

There were mixed comments from people and relatives about the management of the service. Some people and relatives told us that calls could still be late on occasions although they had seen an improvement since the new manager had taken over and the new rotas had been put in place. One relative told us, "If you'd asked me six months ago it would have been a different story" and went on to say the new manager was "Very good" and they had "Seen improvements." Other comments from people included "There is an improvement. I'm more informed" and "Improved for a bit but a few problems this week again. Only hiccoughs. Overall I'm happy." Another relative told us "I received a letter from Agincare, from the [new manager] acknowledging the difficulties. She came out to visit us." Other comments were not so positive. For example, one person said "It upsets my relative when they don't tell them they are going to be late." Another person told us they had contacted the office about late calls and said "They say things but they don't happen." There were several comments about not receiving rotas in time, or rotas changing and people feeling uninformed.

People's records were not always accurate and gave conflicting information to staff. One person's records said they self-medicated but the carer was to apply their creams. There was a list of the current medicines the person was taking. There was a body map with colour coded areas to show which cream was to be applied to which part of the body and a chart which stated the creams were to be applied at each visit. However, this did not correspond exactly to the daily records of the care given in relation to creams which were not recorded as being applied at each visit. We discussed this with the new manager and a member of staff who were both aware of where and when the creams needed to be applied and confirmed the chart was incorrect. They said they would address this as a matter of urgency as part of a review of the person's care.

Some staff told us that although travel time was not included in between visits, they found it was sometimes not enough. One said "It's impossible to get from New Milton to Milford in 5 minutes." Another told us New Milton to Sway, we definitely need more time, you just can't do it in 5 minutes." Other staff said they had enough time, or usually had enough time.

We spoke to the new manager about this and they told us they had implemented a new rota system which had improved the timeliness of home visits, and they were taking other action to try to improve this. For example, they had included five minutes travel in-between each staff members visits. This had all reduced the instances of late calls but was a work in progress and there was still work to be done. People were informed that calls could be within half an hour before or after the stated visit time and this was recorded on the rota that people received. It was not clear whether people's comments about lateness related to the actual time of the visit and not accounting for the half an hour leeway that had been stated on the rota.

There were systems in place to monitor the timeliness of home visits. Staff were required to clock in when they arrived and clock out when they left a person's home and this linked in to the computer system at the office. We looked at the monitoring records and randomly sampled four days of visit logs. These showed that no calls had been later than the half an hour leeway and some visits had been early.

Senior managers were involved with the improvements at the service. The area manager had been working alongside the new manager and making home visits to find out what people's concerns were. Another senior manager had put a temporary hold on the React service as they had not been able to ensure that people received appropriate care due to problems with staffing resources. The provider had recently started to provide the React service again, but was phasing this in slowly to ensure they had the capacity to meet the demand.

Staff were positive about the new manager's leadership and management of the service. They told us they were encouraged to share their views and to give feedback about how the service could be improved. There had been one staff meeting where issues had been discussed to ensure all staff were updated about the new management and changes to how the visits would be organised. They said they were supported in their roles by the new manager and they could ask for information and advice informally on a day to day basis when they went into the office. One staff member told us, "Management are really helpful." Another staff member said "They are nothing but helpful. [The new manager] seems to be turning things around at long last. I find her supportive and she listens to what we have to say. I'm not sure if anything gets done though, no-one ever tells us that bit."

The new manager was knowledgeable about the people in the service and they spent time in all areas of the service daily and monitored staff and the delivery of care closely. The staff we spoke with described how the new manager and area manager constantly looked to improve the service. They discussed how they as a team reflected on what went well and what did not and used this to make positive changes.

Records showed the home worked well with partners such as health and social care professionals to provide people with the service they required. Healthcare professionals confirmed this. Staff told us that there was an open culture at the service and they would not hesitate to raise any concerns if they were witness to poor practice taking place.

The service had a whistle blowing policy in place which staff confirmed they knew about. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. The staff spoken with said they were confident that the new manager would deal with any concerns they had and told us they felt able to raise any issues at their team meetings.

People had the opportunity to give feedback and told us they had been sent questionnaires and letters about the changes at the service. One relative said "We are always told to feedback to them if we're not happy. I would feel able to do that. [The new manager] made it clear that we should contact her directly. Having met her I suspect she would take action."

A number of audits had been carried out to check on the quality of service delivery and to identify what areas required further improvement. Audits included care plans, accidents and incidents, safeguarding, complaints, and staff records. The audits were used to inform the new manager of what action needed to be taken. For example, they had implemented a traffic light system for care plans and colour coded these records with a red, amber of green sticker following the audit so they could see at a glance which required immediate attention. Audits had not always picked up inaccurate records but this was a work in progress and the new manager felt sure that this would be rectified during the reviews of people's care.

Policies and procedures were up to date and related to all areas of the service. Staff knew about the policies and had read them. Confirmation of up to date insurance cover for the service was displayed.