Adriel Care Limited

ADRIEL CARE LIMITED

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Adriel Care Limited is a domiciliary care service providing personal and nursing care to 11 adults and children at the time of the inspection.

Not everyone who uses the service receives personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found

Right Support:
Since the last inspection, the service had changed the emphasis of its work, from short, practical visits to older and physically impaired adults to whole shifts with adults and children with a range of complex needs, including people with a learning disability and autistic people. Staff had received training about learning disability and autism, in line with national requirements. However, whilst care plans addressed the practical care people needed, they were structured in a way more akin to the way the service used to provide care. The registered manager recognised the service needed to develop its practice in line with current good practice for people with a learning disability and autistic people and has since the inspection implemented plans towards achieving this.

The service worked with people's health and social care professionals to help ensure people received the support they needed. The management team recognised circumstances in which people might not be able to give valid consent to aspects of their care and had taken the appropriate action. They had identified where people could be considered as deprived of their liberty and had liaised with care commissioners, who had applied for the necessary legal authorisation.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. The policies and systems in the service required review and updating to support this practice. We have made a recommendation in relation to care and support planning for people with a learning disability and autistic people, and regarding the provider's safeguarding policies.

Right Care:

People and their relatives were involved in the planning and review of their care and support. Care plans were individualised and reflected people's known preferences. They clarified any support people needed with their prescribed medicines.

Right Culture:
People, relatives and staff felt able to raise concerns with the service. Concerns were taken seriously and acted upon promptly. People and, with the appropriate permission, their relatives had access to the computerised records system, which increased transparency and made the service more responsive to their comments. Managers regularly sought feedback from people, staff and relatives and acted on this to improve people's experience of the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection
The last rating for this service was good (published 20 March 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained good. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Adriel Care Limited on our website at www.cqc.org.uk.

Recommendations
At our last inspection we recommended the provider sought appropriate guidance to ensure care plans reflect the framework of the MCA. We also recommended the provider sought appropriate advice and implemented more person-centred care recording. The provider had acted on the recommendations and had made improvements in both areas.

We have made a recommendation in relation to the provider's safeguarding policies.

We have also made a recommendation in relation to strengths-based care and support planning and positive behaviour support when the service works with people with a learning disability and autistic people.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 safe. Details are in our safe findings below.	**Good**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was well-led. Details are in our well-led findings below.	**Good**

ADRIEL CARE LIMITED

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was undertaken by an inspector 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service two working days' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 25 October 2022 and ended on 16 January 2023. We visited the location's office on 25 and 28 October 2022.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority, NHS commissioners and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with five relatives on the telephone and with six staff including the registered manager, who is also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We viewed two care records, four staff files and various records relating to the management of the service, including incident and accident records, staff training records, staffing rotas and quality assurance records.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

The rating for this key question has remained good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Relatives and their loved ones felt safe with staff they had come to trust. Comments included: "We have four nurses [care staff]. I trust them all with [person's] life", "They are very nice people", "Staff are very polite and very understanding" and "They're lovely and I'm happy. It's difficult but successful."
- Two relatives mentioned how they or their families had previously found some staff intimidating or controlling or were not confident in their abilities. The management team dealt appropriately with the complaints and stopped sending these staff to them.
- Staff, including managers, had training about safeguarding people; managers also had training about the manager's role in safeguarding. Staff understood signs that might indicate abuse and knew how to report concerns about possible abuse.
- Whilst the policies for safeguarding adults and children reflected up to date legislation, they did not reference local multi-agency safeguarding policies and procedures and did not include correct contact details for making safeguarding referrals to local authorities. However, the office team, who were generally responsible for making safeguarding referrals, had the right information.

We recommend the service reviews and updates its safeguarding policies to reference and align with local multi-agency safeguarding policies and procedures and to contain correct contact details for making safeguarding referrals to local authorities.

Assessing risk, safety monitoring and management

- Risks to people and to the staff supporting them were identified, assessed and managed. This included people's home environments as well as risks associated with people's care needs, such as moving and handling, skin integrity, nutrition and health conditions. Whilst emotional and cognitive needs were acknowledged, there was a focus on people's physical health needs.
- There was a plan for emergencies that might affect the safe running of the service, such as staff shortages and inclement weather. People's care needs were prioritised in line with potential emergencies.

Learning lessons when things go wrong

- When people or relatives had raised complaints or grumbles, the management team had investigated this. This included meeting with the complainants to understand their concerns further. A relative commented, "Any requests or polite moan, there's no comeback."
- Where people or families had requested a change of staff providing care, their wishes were respected. A relative told us, "I reported two carers [concerns about their competence] … I haven't seen those two for two weeks."
- Staff reported accidents and incidents. The management team reviewed these reports to ensure all

necessary action had been taken for the person's safety and wellbeing, such as seeking medical attention or making a safeguarding referral.
● The management team reviewed accidents and incidents to identify any trends that might suggest further changes were needed to prevent a reoccurrence. Learning from things that went wrong was shared with staff as necessary.

Using medicines safely
● Care plans set out any support people needed with their prescribed medicines and who was responsible for this.
● Where staff were responsible for administering medicines, people received them as prescribed. The computerised care recording system alerted the office team when a medicine had fallen due but had not been recorded as given. The management team reviewed these alerts through the day and followed them up where it appeared a medicine might have been missed.
● Whilst care records showed medicines had been given correctly, relatives had mixed views regarding medication. A relative told us, "[Current care worker] follows the regulations [administering medication] correctly. They'll take it out of the packet. The other care worker didn't." A different relative said, "Another [previous] carer messed up on [person's] medication twice."
● The management team had investigated medicines errors they identified or that had been reported to them. They guarded against repetition, for example, supporting the staff member to reflect on what had gone wrong and providing further training and support where appropriate.
● Staff with responsibility for medicines were trained and assessed as competent in handling them safely. Competence was assessed at least annually.

Staffing and recruitment
● People had a small team of staff who knew them, or were getting to know them, well. Relatives commented, "I know them incredibly well. The staff are a regular team", "It's the same small team. They rotate, there's only about three people", "Apart from a couple of times because of sickness, we've had the same nurse and carer" and "It's difficult when they come in and they don't know [person]. In time we got to a better place."
● Staff new to working with a person had a thorough induction with them, where they shadowed staff who were experienced in caring for the person. A relative explained, "If it's someone new, there's shadowing going on." One relative expressed concern that staff were not always signed off properly. This reflected that until recent months the signing off process had been restricted due to pandemic-related concerns about restricting the number of different staff attending a person's home.
● Staff generally arrived with people when they were due. Relatives told us, "They arrive on time… It is not often that they are late, just a few minutes", "On a rare occasion someone is 10 or 20 minutes late. Some arrive 20 minutes earlier. The agency tends to inform me if they're running late; the night nurse would wait on" and "Five to ten minutes [late] is acceptable, but sometimes it was 30 minutes and more in the past."
● There were enough staff for Adriel Care Limited to meet its commitments to people's care. When considering referrals for new care packages, the registered manager and his team ensured there were enough staff to provide for these.
● Staff completed the training required by Adriel Care Limited as part of their induction and this was updated at regular intervals. The training included moving and handling, basic life support, information governance and safe administration of medicines. Staff also had training and competency assessments in topics relevant to the people they supported, such as epilepsy and administering seizure rescue medicines and enteral (tube) feeding.
● Staff were recruited through a robust process that included giving proof of ID and the right to work in the UK, references and a Disclosure and Barring Service (DBS) check. DBS checks provide information including

details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. A new member of staff had very recently arrived in the UK, was going through the visa sponsorship process and did not have a home address. The service had obtained a police check from their country of origin and would be seeking DBS clearance when the person was in a position to apply.

Preventing and controlling infection

● Staff wore appropriate personal protective equipment (PPE) and observed hand hygiene practices when providing care. A relative commented on how staff always did so, explaining, "Hand washing is very important. Putting their PPE on is my rule."

● When necessary, the office team prompted staff to follow correct infection control practice. For example, a relative had raised concerns that staff were not always washing their hands and said this was addressed satisfactorily. They told us, "They send out a message to the nurses, 'Could you just remember to wash your hands?' I see them do that."

● Staff received training in infection prevention and control, including the importance of hand hygiene.

● There were ample supplies of PPE for staff.

● The registered manager ensured the service's infection control policy was reviewed and updated annually and as required.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

At our last inspection we recommended the provider sought appropriate guidance to ensure care plans reflect the framework of the MCA. The provider had made improvements.
- The service had sought proof of legal entitlement to consent to care on people's behalf, where this had been awarded by the Court of Protection.
- The management team recognised circumstances in which people might not be able to give valid consent to aspects of their care, both children and adults who did not understand the implications of those decisions. For children, they had obtained parental consent, and for adults, had obtained consent from a relative with the necessary legal authority.
- The registered manager and his team had responded proactively in respect of a person who they thought was being deprived of their liberty. They had raised this with the person's care commissioners, who were applying to the Court of Protection to authorise this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were assessed before they started receiving care and care plans were developed based on those assessments, which considered the views and preferences of people and their families. Care needs were kept under review and care plans updated accordingly. Relatives told us, "They came to visit [person] at home before the package started. They came out to see me [also] and we spoke" and "They come out yearly to me to the house and discusses everything about [person's] care and the nurses."
- Relatives said their loved one's care needs were met, although some had not always been satisfied with the care. Comments included: "Staff at the moment know my [family member] very well. [Person] is very

complex", "I like them to become part of the family. This is happening slowly. It's about getting to know [person's] cheeky little ways" and "Some [care staff] are OK, but it's difficult. If they'd listen a bit more and know what their needs are, it would have been better care. The new carers are getting [person] up and give them their breakfast and do their physio."

● Whilst some people using the service had a learning disability or were autistic, assessments and care plans followed a format typical of domiciliary care for older or physically frail people. This covered matters such as breathing, communication, medication, diet and nutrition, continence and skin integrity. Whilst people's care was individualised and their needs were met, assessments and care plans did not focus on people's strengths as is best practice for people with a learning disability and autistic people, nor reference the principles of positive behaviour support. This is an approach to supporting people with a learning disability through understanding the context in which behaviour that others may find challenging occurs and using this information to support them in a way that improves their quality of life.

● The service was becoming involved, alongside the community learning disability team, with the development of one person's positive behaviour support plan. The registered manager recognised the benefits of this approach for upholding the choices and rights of people with a learning disability and autistic people. Since the inspection, the service had recruited a senior member of staff with extensive experience and knowledge of good practice in learning disability care.

● The service's policy for "challenging behaviour, violence and aggression" did not reference positive behaviour support. However, the policy did not conflict with the principles of positive behaviour support.

We recommend the service develops its understanding of strengths-based care and support planning and positive behaviour support, using this to enhance the care of people with a learning disability and autistic people, reviewing care plans and updating policies accordingly, particularly the "Challenging Behaviour, Violence and Aggression" policy.

Staff support: induction, training, skills and experience

● Staff felt well supported through training, supervision and their contact with the management team.

● New staff had induction training that followed Care Certificate requirements and if new to care work would be expected to attain the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

● Refresher training was provided at intervals thereafter. This covered key topics such as moving and handling, basic life support, health and safety (which included food hygiene, infection prevention and control, and control of substances hazardous to health), fire safety and safeguarding. A member of staff told us there were "always updates", meaning staff were expected to complete their refresher training when it was due.

● Face-to-face training had stopped during the height of the COVID-19 pandemic but had recently resumed. Staff told us they had recently had practical moving and handling training.

● The service had paid for staff to have training about learning disability and autism, in line with national requirement for all registered health and social care providers to ensure their staff receive this training at a level appropriate to their role.

Supporting people to eat and drink enough to maintain a balanced diet

● Care plans set out any support people needed from staff with maintaining an adequate dietary and fluid intake.

● Some people needed staff to assist them with taking food through a tube inserted into their abdomen. Staff had training to do this and a registered nurse assessed them as competent. A relative told us, "There's a written-out guide [to the assistance the person needed with nutrition]. They messaged this morning after

[person's] seizures. They got used to feeding them and tube feed through gastrostomy."
● If a person had a safe swallow plan from a speech and language therapist, this was referenced in the person's care plans.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Through choice, people's relatives rather than staff generally liaised day-to-day with health and social care professionals.
● The management team met with health and social care professionals when needed. For example, they were in contact with an occupational therapist regarding how best to meet a person's changing sensory needs.
● Care plans included details of the support people needed with their health conditions. Care records contained contact information for people's health and social care professionals.

Good

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

The rating for this key question has remained good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection we recommended the provider sought appropriate advice and implemented more person-centred care recording, as records were not always detailed and were task focused. The provider had made improvements.

● The provider had introduced a computerised care planning and recording system. This allocated tasks to staff according to the person's individualised care plan; staff signed off each task completed, adding narrative about what they had done. The management team could see immediately whether tasks had been completed in line with care plans. The system also enabled managers to identify themes that needed follow up, such as health concerns.
● Since the last inspection, the service had taken on care packages that required staff to spend entire shifts with people receiving care, for example, providing night care. Whilst continuing to provide care to older and physically impaired people, the service was now supporting adults and children with a learning disability and complex physical needs. The registered manager recognised there was scope for the service to develop good practice in this area.
● The registered manager and staff understood their roles and responsibilities. Staff had regular contact with the management team to discuss their work.
● Quality assurance processes gave the management team an overview of how the service was operating and the standard of care provided. These included audits of various aspects of the service such as medication, care planning and recording and staff records, with action on any issues identified. The management team observed staff practice, and families also reported their own observations to the office.
● The registered manager and wider management team also maintained oversight of the service through regular meetings to discuss what was happening in the service, including reviewing accidents and incidents, complaints and compliments, any changes in people's care needs, staffing and rota cover.
● The registered manager understood and met their legal duty to notify external agencies such as the local authority safeguarding team and CQC of certain events affecting the service, such as safeguarding incidents and serious injuries.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Relatives said they felt able to raise concerns with the service and records of meetings indicated some had become more confident to do so when they saw how an issue had been addressed previously. Comments to

us included: "I text the agency or ring them when I am not happy with them. They respond within half an hour", "Recently they came [to meet] with an assistant manager… If any concerns, I should speak immediately" and "I normally ring the agency and they sort the problems out pretty quickly."
● People using the service and, with their permission or in their best interests if they were unable to give this, their relatives had access to the computerised care record system. The registered manager identified that this made the service more accountable to people and relatives, who now more readily raised concerns: "It can show our mistakes, but it helps to correct us." A relative commented that the service had corrected inaccuracies in their family member's record when they pointed these out.
● Staff were positive about their work and told us they felt well supported by the management team. They said they could readily contact the office with any queries or concerns.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood the requirements of the duty of candour, in the event they needed to exercise this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Relatives said the service involved them in their loved one's care. Their comments included: "They ring me every two weeks and ask how everything is going. It's like a mini assessment on the staff, like 'Are they respectful? Are they early/late?'", "They call weekly if anything has changed for [person]... They're always very pleasant. Any requests or polite moans, there's no comeback" and "The manager said, 'I'm here if anything stresses you out.' They respected the fact I didn't want a nurse back, even after retraining they were offering."
● People and relatives received questionnaires to give feedback about their or their loved one's care. The management team followed up any issues identified.
● Staff confirmed they were kept informed of good practice and changes affecting their work.
● The service worked in partnership with health and social care professionals to help ensure the best outcomes for people.
● The registered manager kept abreast of current good practice through local service provider forums and contact with a registered manager peer support group.