Alina Homecare Ltd

Alina Homecare Brent

Inspection report

Unit 3
Summer Court, 1 Maybury Gardens
London
NW10 2NB

Tel: 02085370674
Website: www.alinahomecare.com

Date of inspection visit:
26 September 2017
29 September 2017

Date of publication:
08 March 2018

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

Our inspection of Alina Homecare Brent took place on 26 and 29 September 2017. This was an announced inspection. 48 hours' notice of the inspection was given because the service is a domiciliary care agency and we needed to be sure that staff were available when we visited.

Alina Homecare Brent is a domiciliary care agency. It provides personal care to older people living in their own houses and flats in the community. At the time of our inspection the service provided care and support to 41 people living in the London Boroughs of Brent and Barnet.

Alina Homecare Ltd had taken over the service from another provider on 15 February 2017. This was their first inspection.

The Service had a registered manager. 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 spoke positively about the care that was provided by the service. The majority of people that we spoke with told us that their care and support had improved during the past year.

People told us that they felt safe when receiving care. Staff members understood how to safeguard the people whom they supported. There were appropriate numbers of staff employed to ensure that people's needs were met and that there was continuity of care in the case of staff absence. The provider had carried out checks to ensure that staff members were of good character and suitable for the work that they were engaged in.

Arrangements were in place to ensure that risks associated with the provision of care and support were assessed and managed. Risk assessments and management plans had been reviewed regularly and updated where there had been changes in people's care needs.

Some people's medicines were administered by staff members and we saw that this was recorded. The quality of these records had been reviewed by the service. Staff had received training in safe administration

of medicines and their competency in this area had also been checked.

Staff received regular training that covered a wide range of topics. New staff members received induction training prior to commencing work with people. They were able to describe the training that they had received and tell us about how it helped them to support the people with whom they worked.

Training and information had been provided to staff about The Mental Capacity Act (2005), including the Deprivation of Liberties Safeguards. Information about people's capacity to consent was contained within their care plans, and staff members were able to describe how they supported people to make decisions and choices about their care.

Arrangements were in place to ensure that staff members were provided with regular supervision by a manager. The records showed that regular supervisions had taken place and this was confirmed by the staff members that we spoke with. Regular spot checks of staff providing care to people in their homes had also taken place.

Care plans were in place detailing how people wished to be supported, and people were involved in making decisions about their care. People told us that they valued the support that they received from their care staff. Staff members spoke positively about their work and the people whom they supported.

The service had a complaints procedure and people told us that they were aware of this. Complaints were monitored and the records showed that these were dealt with immediately and to people's satisfaction.

Regular monitoring of people's views of the service had taken place and we noted that this showed high levels of satisfaction with the service. People and staff members told us they were satisfied with the management of the service.

The service had effective processes in place to monitor the care and welfare of people and improve the quality of the service. Monitoring of care calls had taken place and care documents and staffing records were regularly reviewed.

The service worked in partnership with other health and social care providers to achieve positive outcomes for people.

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. People's risk assessments were up to date and guidance in relation to managing risk was provided for staff delivering care.

Staff we spoke with understood the principles of safeguarding, how to recognise the signs of abuse, and what to do if they had any concerns.

Information about people's medicines was detailed and the quality of medicines administration records was regularly audited.

Is the service effective?

Good

The service was effective. Staff members received regular ongoing supervision from a manager.

A detailed staff training programme was in place and training was 'refreshed' regularly.

The service had policies and procedures on The Mental Capacity Act and information about people's capacity to make decisions was recorded in their care files.

Is the service caring?

Good

The service was caring. People who used the service spoke positively about the staff members who supported them.

Staff members that we spoke with spoke in a caring and respectful way about the people whom they supported.

The provider had arrangements in place to ensure that people were matched to appropriate care staff, and to ensure that, wherever possible, care was provided by staff who they were familiar with.

Is the service responsive?

Good

The service was responsive. Care plans were up to date and

included guidance for staff on how care should be delivered.

Care plans and assessments included information about people's needs, interests and preferences.

People knew how to make a complaint and we saw that complaints had been listened to and acted on.

Is the service well-led?

Good

The service was well-led. People and staff members told us that they thought the service had improved.

A range of quality assurance processes were in place. These were regularly monitored and used to ensure improvements to the service.

Alina Homecare Brent

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 26 and 29 September 2017 and was announced. We gave 48 hours' notice of our inspection as this is a domiciliary care service and the manager may be out of the office undertaking care our assessments. We needed to be sure that a manager was available during our inspection.

The service was inspected by a single inspector. An expert by experience made calls to people who used the service to ascertain their satisfaction. 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 used a range of methods to help us to understand the experiences of people who used the service. We reviewed records held by the service that included the care records for seven people receiving care and support and six staff records, along with records relating to the management of the service. .We spoke with the registered manager, an area manager, a quality manager and four care staff members. We were also able to speak with nine people who used the service and one family member.

Before our inspection we looked at the information that we held about the service. This included notifications, enquiries and other information that that we had received from the service. We also spoke with a representative from a commissioning local authority.

Good

Our findings

People told us that they felt that their care was being provided safely. One person said, "I definitely feel safe with my regular carers." Another person told us, "They always wear gloves and aprons. I do feel they are safe."

The service had carried out risk assessments for the people whom they were supporting which were linked to their care plans. We saw that these were up to date and had been reviewed and amended where there were changes in people's needs. These included information about a range of risks relevant to the person's needs, for example, moving and handling, mobility, falls, skin integrity and pressure sore prevention, eating and drinking and risk within the community. Risk assessments were supported by risk management plans with clear guidance for staff about the approaches that they should use to reduce risk. We saw that they included information about how to support the person's communication needs and preferences in addition to practical information in relation to managing any risk.

People's risk assessments also included information in respect of environmental risk, and safety of equipment. Staff members had received moving and handling training prior to working with people who required this support.

The service had a policy and procedure for administration of medicines. The care files that we saw included detailed assessments of the medicines that people were prescribed and the conditions that they treated. Care staff made records of administering and prompting for medicines and of any failure to take medicines within each person's medicine administration record (MAR). Staff members involved in supporting people with their medicines had received training in safe administration of medicines. We saw that the service had carried out competency checks on staff to ensure that medicines were given safely.

The service had up- to-date safeguarding policies and procedures. Staff members were able to describe types of abuse, the signs and indicators that might suggest abuse, and what they should do if they had a safeguarding concern. Training records showed that all staff had received training in safeguarding. We looked at the service's records and found that no safeguarding concerns had been raised.

We looked at six staff files. Staff recruitment records included copies of identification documents, evidence of eligibility to work in the UK, two written references, application forms and criminal record checks. Staff files also contained training certificates and supervision records. We saw evidence that staff members were not assigned work until the service had received satisfactory criminal records clearance from the Disclosure

and Barring Service.

There were sufficient staff members available to support the people who used the service. Staff members told us that they received their rotas in advance and that they had enough time to travel between care calls. The registered manager told us that, wherever possible, people were supported by the same care staff. Seven people that we spoke with confirmed that they received care from regular staff members who were reliable. One person said, "They have never missed a call," and another said, "They never used to arrive on time but it is much better now." However one person who required support from two carers told us that they did not always arrive at the same time. Another person told us that, "They didn't always turn up and no-one rang me." We spoke with the registered manager and quality manager about this. They told us that on-going action was in place to improve the reliability of care staff. We saw that this was discussed with staff at regular team meetings. An electronic rostering system was in place and we saw that this was monitored on a regular basis. The service provided smart phones to staff to enable them to use this. The service was alerted if staff members were late for a care call and this was immediately followed up by the service. An on-call manager had access to this system outside of office hours. Where there were changes to, or failures in relation to care calls, this was recorded with reasons and followed up by the service as part of the services quality monitoring processes. These showed that there had been recent improvements in the punctuality of care calls.

All staff had received training on infection control procedures and were provided with, for example, disposable gloves, aprons and anti-bacterial gel, along with information regarding safe disposal of these and other relevant waste. We saw that stocks of these were held at the office and staff members told us that they went into the office to obtain new supplies.

All staff members received a copy of a staff handbook at induction. This included information about safe practice and emergency procedures and contacts.

The service maintained a 24 hour on-call service. Staff members and people who used the service told us that they were aware of this. The provider also had a business continuity plan in place that included, for example, actions to be taken in case of severe weather conditions or office closure.

Good

Our findings

People who used the service were positive about the support that they received from staff. We were told, "They seem well trained," and, "I think their training is good but I keep an eye on things."

We looked at the training records for six staff members along with other training information maintained by the service. New staff members were required to undertake four days of induction training prior to commencing work with any person who used the service. The induction to their role also included shadowing of experienced staff. All new staff members were required to achieve the Care Certificate for staff working in health and social care services.

All staff members received core training in a range of skills, such as moving and handling, safeguarding, infection control, medicines administration, food and nutrition and basic life support. Training was 'refreshed' on a regular basis and the service maintained a training matrix which showed when training was due for individual members of staff. The service had also carried out competency assessments of, for example, medicines administration, moving and handling and personal care following staff training. The staff members we spoke with told us that they valued the training that they received. One staff member said, "The training is very good. It really helps me to do my job well."

The quality manager told us that the provider was setting up a training academy. They showed us that staff training programmes in relation to end of life care, stoma care and dementia care had already been accredited by a reputable training organisation. They also said that they were planning to ensure that a wide range of training programmes would be accredited in the future. The registered manager told us that the service was introducing a 'buddy' system for new staff. Experienced staff members would be linked with new staff members and provide on-going support in addition to management support. The 'buddies' would receive an enhanced payment to reflect this additional support. An interview process had taken place and successful applicants were about to undertake training to support them in this new role.

Staff members that we spoke with told us that they received the support that they needed to undertake their duties effectively. The records that we viewed showed that staff supervision by a manager had taken place on a regular basis. Spot checks of care provided in people's homes had also taken place.

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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. The service had a policy and procedure in relation to the MCA and staff members had received training in relation to their responsibilities in relation to this. Staff members that we spoke with understood their roles in supporting people who did not have capacity to make decisions and told us that they would immediately report any changes. One staff member said, "I always check sure that they understand what I am saying. If I think they are getting more confused I would call my manager and let them know."

We saw that people or their representatives had signed their care agreements to show that that they had consented to the care that was being provided by the service. Where people were unable to do so, the reasons for this were recorded.

Care staff were involved in meal preparation for some people, and we saw that care plans and risk assessments for people who were being supported with eating and drinking were clear about the reasons why support was required. They also provided detailed guidance for care staff about how to prepare and deliver food as people required. This included information about preferred food and drink, offering choice, and when and how people should be supported.

People were supported to maintain good health and wellbeing and we saw that information about people's health and medical needs and histories were contained within their care documents. The daily care notes that we looked at showed that staff members had liaised with professionals such as GPs and community nurses where they had concerns about people's health needs.

Good

Our findings

People we spoke with told us that they considered that the service was caring. One said that, "They are very nice. I can't fault them" Another person said, "They are most polite and very caring indeed. They would do anything I wanted, I'm sure, if I asked them."

The staff members that we spoke with talked about the people whom they supported in a positive, caring and respectful way. One staff member said, "I love working with my clients. I learn so much from them as we go along." Another told us, "They look forward to me coming so I make sure that we chat and discuss things they like when I am there."

We asked about approaches to privacy and dignity. Staff members told us that they had received training about this. We saw that there was guidance contained within people's care plans identifying how staff members should ensure their privacy and dignity.

The registered manager told us that, except where there was an emergency, it was important that people were supported by staff members that they were familiar with. They told us that people had a care 'team' so that if their regular carer was away they would be supported by someone who they were familiar with. We saw from people's care plans and the staffing rotas that care was provided by the same regular staff members.

The care plans and risk assessments that we viewed included information about personal histories, interests and cultural and diversity needs and preferences. The service made efforts to ensure that care staff were matched to people on the basis of individual preference and needs. For example, we saw that gender specific care was provided where people had requested this. We also saw that where people communicated in languages other than English, efforts had been made to ensure that they were supported by carers who were able to speak with them in their preferred language.
The service ensured that confidentiality was maintained. Care documents and other information about people were stored in secure cabinets within the service's office. Copies of assessments, care plans and risk assessments were also maintained within the person's home. Training in relation to confidentiality and document management was provided to staff at during their induction.

We viewed information that was provided to people who used the service and saw that this gave clear explanations of the service that was being provided.

Good

Our findings

People who used the service told us that they were pleased with the support that the service provided. We were told, "It has definitely improved," and, "It is better than it was before."

The care plans that we saw were up to date and ensured that care staff had appropriate information and guidance to meet people's needs. Assessments and care plans contained information about people's living arrangements, family and other relationships, personal history, interests, preferences and cultural and communication needs. The assessments also included information about other key professionals providing services or support to the person.

People's care plans were clearly linked to their assessments and were regularly reviewed and updated where there were changes to people's needs. We saw that care plans provided information about each task, along with detailed guidance for care staff about how they should support the person with these. This included, for example, information about how the person liked to be communicated with, how choice should be provided, how to manage behaviours that may be challenging, and how best to support people with their mobility needs. Assessments, care plans and risk assessments were signed and dated.

The notes of care that we saw showed that people had received support that was consistent with their plans. These records were detailed and easy to understand. The quality of care notes was monitored on a regular basis and where there were concerns we saw that these had been discussed with staff members and subsequent improvements had been made. People told us that they were aware of their care plans and that management and other office staff had visited them to review their care needs.

Staff members said that they read and reviewed care plans and care notes at each visit. They told us that were immediately informed about any changes in people's needs. People that we spoke with felt that their care staff were well informed about their needs and preferences.

The service had a complaints procedure that was available in an easy read format. A copy of this was included in a Service User Guide that was provided to all people who used the service at the start of their care agreement. People we spoke with confirmed that they knew what to do if they had a complaint. We looked at the complaints records for the service. We saw that complaints had been investigated and managed in a timely manner and to people's satisfaction. Regular monitoring of complaints and concerns was undertaken as part of the providers quality assurance monitoring.

Good

Our findings

People who used the service told us that they were satisfied with the management of the service. We were told, "I think it's very good. It's much better than it used to be" and, "It seems to run very smoothly." During our inspection we heard members of the office based team speaking with people and following up any concerns with other health and social care professionals.

Staff members that we spoke with were happy with the management of the service and how they were supported. One staff member said "I think the new management is much better than the organisation before. We get more support and I never worry about calling the office if I have a concern." Another staff member told us, "There have been many improvements. The training is better and I meet with my manager more often."

During our inspection we observed that there was a friendly atmosphere at the office. Care staff called in to discuss work or collect items of personal protective clothing. We saw that they were given time by the registered manager and other office based staff to discuss any work issues that they had.

The care files that we viewed showed that quality assurance processes such as on-site spot monitoring, and telephone checks with people who used the service to assess their satisfaction with their care took place. A service user satisfaction survey had been undertaken and we saw that this showed high levels of satisfaction with the care and support that was provided. The majority of people we spoke with confirmed that they had been visited or called by office staff to ask them for their views, or had filled out a questionnaire. However two people said that they did not remember being asked for their views. People had received feedback following the service user satisfaction survey that described the actions that were taking place as a result of their comments. We saw that these actions had been taken.

Regular audits of care files, daily care notes, medicines administration records and staff records had taken place. An electronic system was in place which provided reports and alerts on, for example, care plan reviews, staff training and supervision. Central electronic monitoring of the outcomes of any safeguarding concerns and complaints was also in place.

The provider undertook regular quality assurance monitoring visits to the service. The records of these showed that action plans had been put in place to address areas of concern, and that progress against action plans was reviewed on a regular basis. Weekly monitoring of care calls took place. The Quality Manager showed us a record that identified that the number of late calls had reduced within the past

month. Regular audits of, for example, care records, staff files, complaints and safeguarding concerns were in place. Monthly quality reports from the service were reviewed by the provider's senior management team. These reviews included monitoring of actions taken in relation to any concerns. When we looked at the service's monitoring records, we found that actions identified had been dealt with immediately.

We saw records of team meetings that took place periodically to ensure that staff members were provided with information relevant to the service, and enabled to discuss any issues or concerns that they had. The notes of these meetings showed that they were used to updates on good practice in addition to opportunities to discuss issues of concern or interest to staff members.

Records maintained by the service showed that they worked in partnership with other health and social care professionals. For example, we saw that the service had liaised with mental health workers and community nursing services to ensure that people had the care and support that they required.