Absolute Care At Home Ltd

Absolute Care at Home Limited Head Office

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Absolute Care at Home Ltd on 29 February, 02 and 03 March 2016. As it was a domiciliary care service, we contacted the registered manager one working day before the inspection so that there would be someone at the office when we arrived on the first day. The service was last inspected in August 2013, when it was found to be compliant in all the areas we looked at.

Absolute Care at Home Ltd is a domiciliary care agency providing personal care to 255 people in the Trafford and Stockport areas. Care workers support the people using the service with a wide range of needs, including assistance with washing and dressing, domestic tasks, shopping and making meals.

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.

During the inspection we found that interviews for new care workers were not documented and gaps in their previous employment were not explored. The other aspects of recruitment were done correctly.

Not all care workers recorded whether medicines had been taken on people's medicines administration charts. It was therefore unclear whether people were receiving their medicines as prescribed by their GPs.

The service was not acting in accordance with the Mental Capacity Act as people thought to lack capacity had not been assessed for their ability to give consent or make decisions. Some relatives had signed forms for people who had not had an assessment to determine whether or not they could make their own decisions.

New care workers completed the Care Certificate but records showed that little or no training had been provided for care workers after their induction. Some care workers had not received training in moving and handling, safeguarding or medicines administration for over six years.

The system used to audit the quality of care records was not effective; because the registered manager lacked oversight of the process, this had not been identified.

We found that safeguarding incidents were reported to the local authority, but not always to the Care Quality Commission, as is required by regulation.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. You can see what action we have told the provider to take at the back of the full version of the report.

The service used a rota system which did not include travel time for staff. It was therefore accepted practice

for care visits to be shorter than described in people's care plans so that care workers had time to travel to the next person's house.

Most people and their relatives told us that care workers used gloves and aprons, although some people told us that care workers did not wear aprons or wash their hands without being asked.

People told us that they felt safe when using the service. Staff we spoke with could tell us about safeguarding and said they would report any concerns to their managers. Records we saw confirmed this.

Care workers received an annual appraisal and competency spot check. The service had an informal approach to supervision which the care workers were happy with.

The people we spoke with that received support with food shopping and meal preparation gave us positive feedback. Those supported by the service to make appointments other healthcare professionals were also happy with the assistance they received.

People and their relatives told us that care workers were caring and supported people's privacy and dignity. Care workers could give examples of how they promoted people's independence.

Care workers could demonstrate that they knew people well, as they could describe their likes, dislikes and preferences.

People's personal information was stored securely. They were also signposted to advocates or other specialist support organisations if they needed them.

People and their relatives were involved in developing care plans. People said their care plans were updated regularly and that they received the support they had asked for.

None of the people or relatives we spoke with had made a formal complaint. Records showed that the service acted upon the written complaints it had received in 2015 in accordance with their complaints policy.

The service had an effective system in place for logging and following up accidents and incidents. The registered manager and quality assurance manager met weekly to discuss any issues.

People received an annual survey and were encouraged to feedback about the quality of the service. We saw that the registered manager had acted upon feedback received from the November 2015 survey.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The recruitment process was not fully documented so it could not be evidenced that recruits were suitable to work in the care sector.

Medicines administration was not always documented properly. Records did not show whether people had received their medicines as prescribed.

The system used to rota people's visits did not include staff travel time. Visits were routinely cut short so that care workers could travel to the next care visit.

The provision of care in people's homes had been risk assessed and the service had a contingency plan in place for emergency situations.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not working in accordance with the Mental Capacity Act as the capacity of people living with conditions known to affect their ability to consent had not been established.

New staff completed the Care Certificate but existing staff received little or no training after their inductions.

The people supported with food shopping and meal preparation gave us positive feedback about the assistance they received. The service made healthcare appointments for people who asked.

Is the service caring?

Good

The service was caring.

People and their relatives said staff were caring; they told us that care workers promoted people's privacy and dignity.

Care workers could describe people as individuals and knew their likes, dislikes and preferences.

Care workers promoted people's independence by encouraging them to do as much as they could for themselves and by giving them choices.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred and contained detail about how people preferred to be supported.

People and their relatives told us that they were involved in designing their care plans and said that they were regularly updated.

The registered manager dealt with formal complaints according to the service's policy. People told us the service was responsive when they provided feedback.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The system of auditing care records was not effective and the registered manager did not have oversight of the process.

The registered manager had not reported all safeguarding incidents to CQC in line with regulation.

People were asked for feedback about the service in annual questionnaires. The registered manager had acted upon feedback from the most recent survey.

Absolute Care at Home Limited Head Office

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.

Our inspection took place on 29 February, 02 and 03 March 2016. We telephoned the registered manager one working day before the inspection so that we could be sure there would be someone at the office when we arrived.

The inspection team consisted of three adult social care inspectors. One visited the home care agency's premises and the people in their homes and the other two made phone calls to people and their relatives at home.

As part of the inspection we reviewed the information we held about the service. This included contacting the Trafford Council safeguarding team, the care commissioners in Trafford and Stockport, Healthwatch Trafford and four healthcare professionals who were involved with people using the service. We did not receive a response from the safeguarding team and care commissioners were unable to provide any information other than to confirm that safeguarding referrals had been made to them by the service. District nurses involved with people using the service gave us positive feedback about the care workers and the other three healthcare professionals and Healthwatch Trafford did not respond.

During our inspection we spoke with the registered manager, the quality assurance manager, the operations manager, the office manager, a senior care worker and eight care workers.

We spent the first and third day of the inspection at the service's registered address speaking with staff and looking at records. These included 12 people's care records, four staff recruitment files, six staff training

records, seven staff appraisal and supervision records, various policies and procedures and other documents relating to the management of the service. On the second day of inspection we visited five people who used the service in their own homes and spoke with two of their relatives; this included looking at people's care documents with their permission. After the inspection we telephoned 12 more people at home and six other relatives.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe when they used the service and they said that they did. One person who needed assistance with their mobility told us, "I feel safe when they move me", another person told us, "I have no concerns regarding my safety. They're all very honest I'm sure", and a third said, "I really do feel safe. I don't have to worry about them at all." Relatives also told us they thought their family members who used the service were safe.

We checked the service's recruitment procedures to see if staff suitable to work in the caring profession were employed. We looked at the recruitment records for four care workers and found that all had a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups. The personnel files we looked contained the original application form, two written references and copies of photographic ID. We noted that each recruitment file contained a record of interview form but found that three of these were blank and the other contained details of the shifts the prospective employee wanted. This meant that there was no record of how the service had established candidates' suitability to work in the care sector. In addition, each candidate's application form had gaps in previous employment and the service had not documented how these were explored.

This constituted a breach of Regulation 12 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the people using the service were supported with their medicines. We looked at the printed medicines administration charts (MARs) care workers used to record medicines for seven people and found issues with all but one of them. Six of the MARs had blanks where care workers had not signed to say that medicines had been taken at a particular visit when they should have been; some care workers added a dash or cross to the MAR where they would sign, and it was not clear what this meant. We checked the care records to see if on the days where the MAR was not signed or had a dash or cross added, the care worker had recorded administering medicines there instead. One person's MAR for a topical cream to be applied at bedtime was blank between 19 and 31 July 2015. In the care record for this time period, the application of the cream at bedtime was recorded four times but not for the other nine nights. Another person's care plan stated that they were to be assisted with two topical creams and some eye drops. We saw on their January 2016 MAR that an emollient cream was marked with a dash for 10 days of the month. The MAR for the other cream (an anti-fungal) that should be applied twice a day was totally blank, as was the MAR for the eye drops that were to be given daily. MARs for September and October 2015 for this person were similar, with the emollient cream recorded erratically on the MAR and the section for the anti-fungal cream and eye drops totally blank. Care records for this person reported the application of a cream to the person's legs, but did not specify which cream had been applied, and did not mention eye drops.

On the MARs of two people we saw that care workers had hand-written new medications prescribed after the MAR had been printed: two medicines on one MAR and one medicine on another. Rather than informing the office that a new MAR was required, care workers had added all three medicines to the blank space at

the bottom of the MAR. Badly drawn tables had been used to record when medicines had been taken. The addition of new medicines to MARs in this way could lead to medication errors and therefore put people at risk.

All of the people we spoke with who were supported to take their medicines told us they were happy with the care they received. We spoke with the district nurse team who worked with people using the service; they told us that care workers applied topical creams correctly and as prescribed, although they did not check MARs. One relative was less happy as they felt their family member was not being prompted to take inhaler medication, even though it was in their care plan. Negative feedback was also received about medicines administration in the November 2015 client survey, which some people had been assisted to complete by their relatives. One survey stated, "No, medicines have not always been given", and another said, "The MAR sheet is often not completed."

We raised these issues with the registered manager. She could not explain why care workers were not recording medicines administration on people's MARs and did not know what a dash or cross in the box where a signature should go signified. She agreed that care workers hand-drawing tables on the bottom of MARs when new medicines were prescribed was not good practice and said that when this happened care workers usually contacted the office so that a new MAR could be printed and sent out. The registered manager said that she would investigate the issues with the recording of medicines administration and ensure improvements were made.

The issues with medication recording constituted a breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service were supported by care workers who visited their homes during a set window of time for an agreed duration. We asked people if care workers arrived at the same time each day and the feedback was mixed. People told us, "They aren't always on time. It varies", "Times vary a little bit", "They come early or late and I often have to call to ask if they're coming", "They come the same times thereabouts", and, "Call times can vary by 30 to 45 minutes and that's a problem." We asked people if the service telephoned them to let them know if care workers had been delayed and were told that this did not happen. One person said, "If they're going to be late they should ring, but they don't." The failure to notify people about late visits was a finding of the November 2015 client survey, as 76% of people who responded to the survey said that they were not notified when care workers were going to be more than 30 minutes late.

People also told us that they had few regular care workers and frequently had new ones they had not met before. People told us, "We've had so many different ones it's unbelievable", "I keep having different people (care workers)", "They keep swapping and changing", and, "I get a lot of different carers. The staff change all the time. Maybe the same one comes for two or three mornings, then there's a change." However, those people that said care workers varied did say that whilst they preferred regular care workers, they did not mind seeing new ones.

We asked if care workers stayed for the duration they were expected to at each visit. People told us that either they did, or if all their care needs had been met, the care workers would ask permission to leave early to get to their next call. People told us that they did not mind when this happened. Three people told us they either felt rushed by care workers or that care workers seemed in a hurry; one said, "They don't have enough time. They're always behind themselves and have to dash off", and a second commented, "They always seem to be in a hurry." We checked the care records of five people to see if care workers stayed for the allotted time. One person received four 30 minute visits a day; records showed that for the six days before

our inspection, over half of these visits lasted 20 minutes or less. The care records of the other three people we looked at showed that the majority of visits were for the agreed duration or were at most five to ten minutes shorter. We raised this with the registered manager and she said that each of these visits complied with the timeframes agreed with the local authority who funded the majority of care.

We also spoke with the registered manager about the timing and allocation of people's care visits and the changing care workers. The registered manager acknowledged that people did often see different care workers but said that this was inevitable if people had numerous visits a day, seven days a week. She also told us that the service tried to complete visits at the times people preferred but due to emergency situations or traffic, this was not always possible.

We noted that the service did not allocate travel time between visits so care workers' rotas had back to back visit times so we asked how this worked. The registered manager said that the local authority who commissioned the majority of care allowed care workers to leave care visits early by the equivalent of 10% of the total visit time. This time was used for travelling to the next person. Care workers we spoke with told us that most visits were about five minutes apart and that travelling was manageable, however, one care worker told us they would start their care visits early to prevent getting behind and another said they used their break between morning and afternoon visits to catch up. This meant that rotas were organised so that time allocated for care visits was used by care workers to travel to the next person; it was therefore accepted practice that the majority of people's care visits would be cut short to a greater or lesser degree.

Some of the people using the service received assistance from care workers with their personal care, for example, with washing and dressing and continence. We asked people and their relatives if care workers always washed their hands and used personal protective equipment, such as gloves and aprons, when assisting with personal care. All of the people we spoke with said that care workers used gloves but that not all used aprons or washed their hands on arrival prior to donning gloves and providing care. One relative expressed concern that care workers used gloves from their uniform pockets, not fresh from a box, and was therefore not sure if they were clean. This relative also said that they had to ask care workers to wash their hands when they arrived as they did not automatically do this and had also asked the service to provide care workers with aprons to wear. Two other people assisted with either personal care or topical creams said that care workers did not wear aprons; one of these said that they never saw care workers wash their hands or use alcohol gel and assumed they did this before entering their home.

We checked the service's infection control policy. It stated that care workers should wash their hands upon entering a person's home and before leaving (and at various other times) and that aprons should be worn when dealing with body fluids, for example, when assisting people with continence care. Not wearing aprons or handwashing when required meant that care workers were not following the service's infection control policy and could therefore put people at risk of infections.

We asked the care workers we spoke with to describe the forms of abuse people using the service might be vulnerable to and they could. Care workers also said they would report any suspicions of abuse to their managers. One care worker told us, "You just know when something isn't right." We saw in records at the service that care workers did report concerns they had about the people they supported to the senior care workers. This meant that care workers were vigilant in terms of identifying and reporting any concerns they had regarding the people they supported.

The service had a contingency plan for various emergency situations, for example, loss of electricity at the office and extreme winter conditions. We also saw that people's care files contained risk assessments for medicines, various aspects of the home environment and any assistance with moving and handling that

people required. This meant that the service was aware of the risks of providing care to people in their homes and had assessed them appropriately.

Requires Improvement

Is the service effective?

Our findings

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 make particular decisions any made on their behalf must be in their best interests and as least restrictive as possible.

People who live with conditions such as dementia or those with learning disabilities may have a variable ability to make decisions; for example, one person may be able to decide what to eat or wear, but may not be able to decide how their financial affairs are managed. Some people can make decisions with the support of others. If people are unable to make their own decisions, they can be made for them under the MCA in their best interests. The MCA states that we should assume all people have the ability to make their own decisions; only when it is thought that a person may lack capacity are assessments required to establish if this is the case. Other people, including next of kin, cannot legally make decisions on someone's behalf unless they have lasting power of attorney.

We looked at the care files of two people diagnosed as having dementia and one other person thought to have dementia. Their care plans included details of the tasks to be completed by care workers at each visit, but had no information about how the person's dementia affected them or their ability to give consent or make decisions. The risk assessment in each person's file had a section on capacity, for these three people it was recorded, '[relative] takes care of finances', 'family support', and, '[relative] supports with shopping and finances.' It was not made clear whether the family members had lasting power of attorney to make decisions for the people. Another person was recorded as having a learning disability, although there was nothing in their care file about how this might affect their ability to give consent or make decisions. This meant that the capacity of people to consent to receiving care had not been established.

In the care files of two people that did not have dementia, or any other issue that suggested a lack of mental capacity, we noted that the service user agreement between the person and Absolute Care at Home Ltd had been signed by a relative. There was no reason given as to why this was the case. Care plans of two other people who had mental capacity included instructions from family members that had been added for care workers. One stated, 'Do not "ask" [name] if [they] want personal care – just do it', and the other stated, 'If [name] refuses any form of care, carers must log/report and inform [a relative].' This meant that people may have been receiving care without their consent.

We asked staff if they had received training on the mental capacity act; most said they had and all could give examples of how they obtained consent from people prior to assisting them with personal care. We discussed our findings regarding consent and capacity with the registered manager. At first she did not accept that care workers or the domiciliary care agency itself had a role in assessing people's capacity to make decisions or that they could make decisions for people as she did not think that she or the care workers were 'qualified' to do this. After discussion, she said that staff training would be provided, people's capacity would be assessed (if required) and their care plans amended.

The lack of adherence to the principles of the MCA constituted a breach of Regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the people and their relatives if they thought the care workers who supported them were well trained. People told us, "Yes, they're very good. New ones need to learn the ropes", "Oh yes, I think so", "Yes, in general", "I think so yes, but if they're new I have to tell them what to do." A relative told us, "Staff seemed to be trained. They are OK when lifting [name]."

The care workers we spoke with told us that they had received training to undertake their roles. We checked the training records of six care workers who had started working for the service in either 2008 or 2009. Each care worker had received an induction which included all of the mandatory aspects, such as medicines administration, moving and handling, infection control and safeguarding, however, we found that they had received little or no relevant training since. Five care workers had not received safeguarding, medicines administration or moving and handling training in over six and a half years; two other care workers had last received moving and handling training in 2012 and 2013, respectively, and one of them had last received training on medicines administration and safeguarding in 2010. As noted previously in this report, we identified issues with medicines administration which suggested that training was required. This meant that following induction, care workers received little or no further training on important aspects of their roles.

We discussed the lack of training with the registered manager. She said that this had already been identified and confirmed that a plan was in place to provide training for those care workers that required updates.

At the time of inspection the service had not ensured that all staff employed received the appropriate training and support necessary for them to carry out their duties. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the service used the Care Certificate for employees joining the service who were new to adult social care. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care. We checked the training records of three people employed in November 2015; they had each undertaken the Care Certificate and this was recorded fully in their files. The registered manager explained that the Care Certificate formed part of the service's two week induction, which included classroom sessions, shadowing more experienced care workers and all of the required mandatory units, such as safeguarding, medicines management and moving and handling. This meant that new employees were trained appropriately for their roles.

Care workers told us that they received annual appraisals which were preceded by spot checks from senior care workers to assess their competence. These spot checks took place in people's homes during care visits; care workers were assessed in terms of how they interacted with the person, whether they encouraged people's independence, whether they offered choices to the person and on their appearance. Records we saw supported these checks took place. We noted that supervision sessions were not recorded in care workers' files; care workers told us that they did not get regular formal supervision but all told us that they did not find this a problem. They said, "I just come in and speak to them (senior care workers) if I have a problem", "I don't think I need regular supervision. If I've got any problems I just come in", "I can talk informally to my manager anytime", and, "I feel I can raise stuff as and when." We asked the registered manager about the lack of formal supervision and she agreed that it did not take place but felt that logistically it was difficult to do this as many domiciliary care workers fitted the job around a busy family life or other commitments. She explained that the service preferred to encourage care workers to come into the office to talk informally if they needed support or had problems and that most did this when dropping off

time sheets or collecting personal protective equipment. Our discussions with care workers showed that they liked this approach and felt able to raise issues with their managers.

Some of the people we spoke with were supported with food shopping and meal preparation. Each person said that they were happy with the support they received and the meal choices care workers provided them with. People told us, "They do my shopping for me; I tell them what I need. They even get me fish and chips when I ask", "They do my food shop, they know what I like", and, "They do give me a choice. It depends what's in the fridge." Other people said that care workers would ask if they needed anything taken out of the freezer for later in the day. This meant that people were supported to eat the foods they chose.

We asked people if care workers helped them to book appointments to see other healthcare professionals, such as GPs or district nurses. Most said they managed this themselves or were assisted by a family member, but some people told us that care workers did help do this on occasion. One person told us, "One of the ladies (care workers) has phoned the doctors to make an appointment." Another person said that a care worker had called to make an appointment for them on the day we visited because they had trouble using the telephone. Care workers we spoke with said that if people asked them to make appointments they called the office so that information could be logged on the electronic system and shared with others if it needed to be. This meant that the service supported people to maintain their holistic health when they asked for it.

Good

Is the service caring?

Our findings

We asked people and their relatives if they thought the care workers who supported them were caring. The response we received was unanimously positive. People told us, "Yes, they're very caring", "They're very nice people", "They're very, very good. Some are shining examples", "It's like a friend coming", and, "They are very good and they listen to me." Relatives we spoke with also thought the care workers were caring; they said, "They're very caring", "The staff are very pleasant and like to chat, which is good for [name]", and, "They are always very nice and supportive."

As part of the inspection we wanted to find out whether care workers respected people's privacy and dignity and knew them well as individuals. All of the care workers we spoke with could describe the people they supported regularly in detail, including their likes, dislikes, preferences and the way they asked to be supported. They also gave us examples of how they promoted people's privacy and dignity. One care worker said, "I shut the curtains and I make sure I never discuss people outside of work", another care worker said, "I give people privacy when they use the toilet when it's safe and keep them covered as much as possible when I help them get washed." All of the people we spoke with said that care workers respected their privacy and dignity. The service was also in the process of working towards the Dignity in Care accreditation which is awarded by Trafford Council; Dignity in Care awards recognise care providers willing to go the extra mile to make sure people are treated in a dignified and respectful way. This showed us that the service promoted people's privacy and dignity.

Care workers told us how important it was to help promote people's independence so that they could stay in their own homes for as long as possible. One care worker told us, "I let them do as much as they can do", a second care worker said, "If I'm making them a meal, I ask them if they want to help", and a third said, "I give people as much choice as I can, for example, what clothes to wear, perfume to use, food to eat and TV channel to watch." The people we spoke with agreed that care workers always gave them choices when supporting them. This showed that care workers tried to promote people's independence by encouraging them to do things themselves and by providing choices.

We visited the office of Absolute Care at Home Ltd as part of our inspection. We found that both electronic and paper documentation was stored securely so that people's confidentiality was properly maintained.

We asked the registered manager if any of the people they supported had an advocate and she said they did not as most had relatives that did this for them. The registered manager said that she would ensure people were referred to advocates if a need arose and gave examples of referring people and their relatives to organisations such as the Alzheimer's Society and the Multiple Sclerosis Society for more specialised advice and support. The registered manager also stated that if they had specific concerns about a person, they would notify the local authority so that they could provide additional support. This meant that people were provided with details of advocacy services or other relevant services when they needed it.

Good

Is the service responsive?

Our findings

As part of this inspection, we looked at the care files of 12 people who used the service at the office and at five other people's (with their permission) in their own homes. Each person had a front sheet which listed their next of kin details and information about the other healthcare professionals involved in their care. There was also a summary of aspects such as the person's vision, hearing, communication skills, mobility, medications and a brief medical history. A short section contained some personal history of the person and then the plan contained a detailed list of tasks which the care worker was to undertake at each care visit. We saw that the plans were person-centred and individualised to the person's needs, containing details of the support they needed and the order they preferred to receive that support, as well as how they liked their hot drinks, what foods the enjoyed and anything they did not like. Care plans included the support people needed with aspects such as personal care and continence and provided detail in terms of any moving and handling that was required or pressure area care.

We asked people how they were involved in planning the care and support they received. Every person we spoke with said that they had received an initial assessment where they were asked what support they required and what their preferences were. Those people with family members that they saw regularly said that they were also invited and contributed to the care planning, with their permission. One person told us, "We were all involved in the planning. They came and reviewed it a couple of months ago." Relatives also confirmed that they had been involved in the care planning process; one told us, "I've been involved in the assessment." People we spoke with they felt confident they could change their care plans if they wanted to and that they were reviewed regularly. They were also happy that they always received the support that they had asked for. This meant that people were involved in planning and individualising their own care and confirmed that they received it.

As noted earlier in this report, people told us that they frequently saw care workers who were new to them, so we asked care workers how they made sure they supported people appropriately when they had not visited them before. The care workers we spoke with all told us that they would read the person's care plans upon arrival after greeting them. One care worker said, "I'd read their care plan, their medical history and the other carer's logs", a second said, "I'd read the care plans and ask them things, how they liked stuff doing", and a third replied, "I'd introduce myself and then read the care plan and previous logs." People confirmed that care workers new to them did read their care plans. One person said, "They follow the care plan, but they always ask if there's anything else they can help me with", and a second said, "They check the red folder (the care file). They always ask me 'is there anything else you want?' They're very good like that."

We looked at the daily records of eight people who used the service. Daily records are completed by care workers at the end of each visit; they should describe the support the person received and make reference to people's care plans in order to evidence that people have received the support they asked for. The daily records we read were concise and, with one exception, contained information which demonstrated that people were supported according to their care plans. This meant that care workers documented the support that they were providing.

The service had received three formal written complaints in 2015. We read the complaints and the documentation relating to each investigation and resolution and compared the procedure taken to the service's complaints policy. It was clear that the registered manager had resolved each complaint in a timely fashion in accordance with the policy. We asked people and their relatives if they had ever made a complaint about the service. No one we spoke with said that they had made a formal complaint, and all knew how to make a complaint if they needed to. One person told us, "I haven't made a complaint. They have always done what they are supposed to. I have got no complaints." We noted that the service user information document that was in the care file of each person we visited at home contained the service's complaints policy. Some people did describe occasions when they had provided feedback informally to the service about things they were not happy about. One person said that had not got on with a particular care worker and had rung the office number and asked that the person did not support them again, and this had happened. Another person did not want tell us the nature of their complaint but said, "I gave them feedback and they acted upon it quite quickly." This meant that the service investigated and resolved formal complaints in a timely manner and acted upon informal feedback to resolve problems.

Requires Improvement

Is the service well-led?

Our findings

We asked people and their relatives if they thought that Absolute Care at Home Ltd was well managed; people told us, "Yes, I do yes", and, "I think so." We also asked the staff what they thought of the managers; they told us, "The management are good. I find them very easy to talk to", "They're very friendly and approachable. I really like working for the company", "The managers are very understanding and supportive. I find it a very rewarding job and totally 100% love it", and, "I find them very easy to talk to. I love my job, it doesn't feel like work."

As part of the inspection we asked the registered manager and quality assurance manager how the service was audited for safety and quality. The registered manager explained that each month the senior care workers would visit each person's home to collect the care documentation that needed to be archived. As part of this process, the senior care workers would check the care records written by the care workers to make sure that they evidenced that people were receiving care according to their care plans. They also checked the medicines administration records (MARs) and looked at visit times to make sure care workers stayed for the duration of their calls. These audits were recorded on a front sheet which was attached to the care records it related to. We looked at three audits and found issues that had not been identified by the senior carers as requiring action. The first audit noted that some care workers had not completed MARs when medicines had been administered. The senior care worker had documented that the care workers responsible had been spoken to about this, however, the handwriting of new medicines to the bottom of a MAR was not identified as a problem. The second audit concluded there were 'no concerns' and 'no issues' on the front sheet. However, we found that MARs had not been completed correctly and that exactly the same two sentences had been added to the care record by a care worker for every care visit in January 2015. We checked this person's care plan and found that other support was needed by the person in addition to the care documented so it was not clear whether or not the person was receiving it. The third audit also failed to recognise that the record of medicines administration was poor.

We raised our concerns with the registered manager about the quality of care record audits and asked what her oversight of the process was. The registered manager acknowledged that issues should have been identified and said that neither she nor the quality manager had oversight of the care record audits completed by senior care workers. On the last day of our inspection the registered manager amended the audit front sheet with prompts that would ensure auditors checked a range of care aspects, including the completeness of MARs, care record quality and call duration in the future. She also said that she would start checking a regular sample of the care record audits to make sure they were done correctly in future.

At the time of our inspection the service did not have an effective system in place to monitor and assess the quality of care records. This was a breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of this inspection we checked the safeguarding incidents and concerns that had been recorded by the service in 2016 until the time of our inspection. In line with regulation, certain accidents or incidents must be reported to the local authority and to the Care Quality Commission (CQC). When we checked the

records we found that 13 safeguarding incidents had occurred in January and February 2016 which had been notified to the local authority but not to CQC. We saw that the referral information provided to the local authority was detailed and appropriate; it demonstrated that care workers were vigilant in terms of reporting concerns to their managers and that the service was passing those concerns on to the local authority. We discussed the requirement for safeguarding notifications with the registered manager and clarified the circumstances when they are required.

Failure to report safeguarding incidents to CQC was a breach of Regulation 18 (2) (e) of the Care Quality Commission (Registration) Regulations 2009.

The service had an effective system in place for the logging and follow up of any incidents, accidents or concerns. During office hours, care workers phoned any problems through to the office so that they could be logged on the care planning system. Out of hours, these were recorded by the on-call care worker and added to the care planning system first thing the next day. The registered manager and quality assurance manager were alerted when new incidents or concerns were raised, and only they could record actions and close incidents down on the care planning system. They also met weekly to discuss any issues or problems that had occurred or were ongoing. We checked the concerns raised by care workers relating to the safeguarding of people using the service and saw that the registered manager and quality assurance manager had taken the appropriate action. This meant that the registered manager had oversight of all the incidents and accidents that occurred at the service and we saw examples that showed the correct action was taken.

People received an annual questionnaire from the service to ask for their feedback. The last questionnaire had been sent to people in November 2015 and we looked at the responses that had been received. The people who were surveyed were positive about most aspects of the service; some of their comments included, "They are cheerful and friendly", and, "I have been very happy with the carers." Some less positive feedback was received about variable care visit times. We asked the registered manager how she had used the outcome of the survey to improve the service. She told us that in 2016 the service had introduced a new electronic visit planning system which meant that care workers should be scheduled visits that were closer together. The aim was to cut down on travel time so that care visits would be longer. The system had only just been put in place at the time of our inspection so it was too soon to assess whether there had been any improvement. Taking action to try and reduce travel times meant that the registered manager had responded to the outcome of the annual client survey.

As part of the inspection, we wanted to find out if care workers understood the vision and values of the service and how the registered manager communicated these to the staff. When we asked the care workers what the service's vision and values were they told us, "To keep people well at home. To make sure they are independent and healthy", "I want to make elderly people more independent and make sure they get the care they need", "To re-enable clients back to independence so they can live in their own homes", and, "To make clients' days a little bit brighter." The registered manager said that the vision and values of the service were communicated to the care workers during the induction process and at their annual appraisals; she told us, "We set out to create a service that was compassionate, caring and friendly but also effective and professional." The service used a weekly bulletin which went out with rotas on Fridays to give updates about the people using the service, as well as important news, and any compliments or complaints. We asked if staff meetings were held. The registered manager said that arranging staff meetings for over 100 employees during the day when care visits were taking place was not feasible. She said that care workers were encouraged to come to the office if they had any concerns or just to chat with managers; care workers told us they did this and were happy with the arrangement. This meant that the care workers knew the vision and values of the service and, according to feedback given to us by people and their relatives, this underpinned

the care that they provided.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Safeguarding incidents were not always reported to the Care Quality Commission. Regulation 18 (2) (e)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not act in accordance with the Mental Capacity Act. People thought to lack capacity had not been assessed. Regulation 11 (1) (3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not document interviews or how gaps in employment had been investigated. Regulation 12 (1) and (2) (c) The administration of medicines was not documented properly. Regulation 12 (1) and (2) (g)

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The system in place for the audit of care records was not effective. Regulation 17 (1) and (2) (a) (b) (f)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive regular training appropriate to their roles after their induction period. Regulation 18 (2) (a)