Alma Care (UK) Limited

Alma Care (UK)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place 6 June 2018 and was announced. We gave the registered manager 48 hours' notice of the inspection visit because the service is small and we needed to be sure the registered manager would be available.

At our last announced comprehensive inspection of this service in October 2017 we rated the service 'Requires Improvement' overall because we found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to safe care and treatment, safeguarding, consent, person-centred care, good governance and submitting notifications to the Care Quality Commission (CQC). The provider sent us an action plan setting out when the required improvements would be made. Some of these actions have been completed.

We found breaches of the regulations relating to safe care and treatment, fit and proper person's being employed, the provider's failure to submit statutory notifications and good governance. The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Alma Care (UK) is a domiciliary care agency that provides personal care and support to people living in their own homes, many of whom were older people. Not everyone using Alma Care (UK) receives the regulated activity. CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided. Most people using the service lived in Surrey.
The service had a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The registered manager told us there were nine people receiving the regulated activity (personal care) from Alma Care (UK) at the time of our inspection. After speaking to Alma Care (UK) staff and representatives of Surrey County Council, it appeared that Alma Care (UK) were providing the regulated activity to at least 13 people. As there was a discrepancy in the number of people the registered manager told us was using the service, on five occasions after the inspection we asked the registered manager to confirm the number of people using the service. These requests were responded to promptly but on each occasion the information supplied was incorrect. We have sent the provider a requirement letter. This means the provider is required under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provide us with information we have requested relating to the safety of people using the service.

At our previous inspection we found the provider did not always assess risks to people to ensure robust

management plans were in place to reduce the risks. At this inspection, the provider had improved the assessment process so that people had personalised risk assessments and risk management plans in place. This included risks relating to people's health needs.

The provider did not always manage people's medicines safely. The provider did not know the number of people that staff were supporting with their medicines. In addition, the systems in place in relation to medicine administration were not sufficiently robust to help ensure people received their medicines safely.

Staff had received training in how to recognise and report abuse. They knew how to report any concerns and were confident that any allegations made would be fully investigated to help ensure people were protected. However, the provider did not notify the CQC of an allegation of abuse as required by law. This meant the CQC did not have oversight of and could not fully monitor any risks associated with the service.

Appropriate checks were carried out on staff before they began to work with people. However, when these checks revealed that an applicant had a criminal record, the provider did not conduct a risk assessment or give any consideration as to whether it was safe for the applicant to work with vulnerable people. The provider deployed a sufficient number of staff to meet people's needs. The provider continued to support staff with relevant induction, training, supervision and appraisal.

The provider had improved the systems to provide care in line with the Mental Capacity Act (MCA) 2005. The provider now investigated whether family members had legal capacity to consent on behalf of people and carried out mental capacity assessments when necessary.

The provider was now working more closely with people in developing and reviewing their care plans. The care plans we had access to were person-centred. Staff knew the people they supported well. People were treated with respect and their privacy and dignity were maintained. People received the support they needed in relation to eating and drinking and the provider supported people in relation to their healthcare needs.

People were satisfied with the care and support they received. They told us they were supported by a consistent staff team whose punctuality had improved recently. In addition, staff supported people to maintain their independence.

The provider had improved the processes for obtaining people's feedback and using this information to improve the service. The provider had an appropriate complaints policy in place and people knew how to make a complaint.

Some aspects of the service were not well organised. The provider did not have effective systems in place to monitor, assess and improve the service. This was because the provider had not identified the issues we found during our inspection.

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 provider did not have appropriate systems in place to ensure people received their medicines safely.

The provider did not ensure that staff were suitable for the role for which they were employed.

The provider deployed sufficient staff to meet people's needs.

Staff had good knowledge of how to protect people from abuse and report their concerns.

Is the service effective?

Good

The service was effective.

Staff continued to receive relevant induction, training, supervision and appraisal.

People's needs were assessed including their capacity to make decisions. Staff understood the main provisions of the Mental Capacity Act 2005.

People received the support they required in relation to eating and drinking. Staff supported people to maintain their health.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider did not know how many people were using the service.

Staff were caring and treated people with kindness.

Staff knew the people they were caring for well and supported them to maintain their independence.

Is the service responsive?

Good

The service was responsive.

People were involved in planning and reviewing their care. People's care plans reflected their needs and preferences.

The provider had improved the systems to obtain feedback from people and their relatives.

Is the service well-led?

Inadequate

The service was not well-led.

Suitable systems were not in place to monitor, assess and improve the quality of the service and the provider had not identified the concerns we found during our inspection.

The provider did not know the number of people using the service or who staff were supporting with their medication which meant that they had no way of checking that the care people was receiving was appropriate and safe.

The provider did not submit statutory notifications to the Care Quality Commission.

Staff were well supported by the provider.

Alma Care (UK)

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 checked 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 was a comprehensive inspection. The inspection took place on 6 June 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office and we needed to be sure that they would be in. This inspection was carried out by a single inspector and an expert by experience.

Before our inspection we reviewed information we held about the service. This included information our previous inspection report.

During the inspection we spoke with the registered manager who was also a director of the company, as well as the office manager. We looked at a range of records including four staff files, six people's care plans and other records relating to the management of the service.

After the inspection we spoke with three people using the service, three relatives and four staff. We also liaised with representatives of a local authority which commissions the service.

As there was a discrepancy in the number of people the registered manager told us was using the service, on five occasions after the inspection we after asked the registered manager to confirm the number of people using the service. These requests were responded to promptly but on each occasion the information supplied was incorrect.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in October 2017, we found the provider did not always manage people's medicines safely. During this inspection we found that this had not improved. The registered manager told us that one person using the service was supported to take their medicines. However, it was clear from speaking to people, their relatives and staff that this was incorrect and that staff were regularly supporting at least three people to take their medicines and another person was supported on an ad hoc basis. One person told us, "I usually give [the person's] medication but if I have to go out the carers do it. I don't think they complete any paper work or at least there isn't any in the house." This person's care plan did not state that staff were to support this person with their medicines. Other people told us, "They help me with my tablets every day" and "They help me to get washed and dressed and give me my tablets."

Staff administering medicines were required to complete medicine administration records (MAR). We asked to see the MAR for the person the registered manager told us staff supported with their medicines. The registered manager gave us one MAR which was undated. Without accurate, signed, up-to-date and audited MAR the provider could not be assured that people were receiving their medicines safely or in line with the prescribers instructions.

These issues amount to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have effective systems in place to audit the management and administration of people's medicines. This is dealt with in more detail under the "Well-led" section of this report.

The provider's recruitment procedures were not sufficiently robust to help ensure that only applicant's suitable for the role of supporting vulnerable people were employed. Pre-employment checks were conducted. These included obtaining professional references, proof of identity and the right to work in the UK as well as criminal record checks. However, when we checked staff files we found that criminal record checks had revealed that a job applicant had been convicted of a criminal offence. The provider had employed this applicant and allowed them to work alone with people knowing they were not of good character. The provider did not carry out a risk assessment; could not provide a record that any consideration had been given to this person's suitability for the role of caring for people; or kept a record of the decision-making process. We raised this with the registered manager who told us the conviction was a long time ago so she thought the applicant would be fine to work with people.

The provider's failure to give appropriate consideration to and record reasons why an applicant with a criminal record was deemed suitable to work with people is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we found there were not always enough staff deployed to care for people which meant that staff were late for scheduled visits to people and sometimes did not attend at all. During this inspection we found the he provider deployed a sufficient number of staff to meet people's needs. The

provider had recruited two additional staff members since our last inspection. People told us that staff punctuality had improved since our last inspection and that staff were now rarely late. People commented, "They used to be late all the time but they have been much better recently", "That isn't a problem for us now" and "Their time-keeping has definitely improved recently." One person commented, "They don't turn up on time. They are meant to be here at 10.00 but sometimes turn up at 10.30. We complained to the carer and it has got a bit better."

People told us they felt safe. They commented, "I'm safe with my carer", "I think I'm safe with them" and "They have never been inappropriate." Relatives told us, "They've never given me any reason to doubt [the person] is safe with them. I feel comfortable leaving [The person] alone with them when I have to go out" and "[The person] would let me know if [The person] wasn't comfortable with the carers." Staff we spoke with had good knowledge of how to identify abuse and report any concerns to the registered manager and external organisations.

At the previous inspection we identified improvements were required in relation to the way the provider identified and assessed risks to people. Since that inspection, the provider had employed an additional staff member whose role included the tasks of carrying out risk assessments and devising care plans. The risk assessments and management plans we had access to were personalised and covered a variety of risks including those associated with people's health and home environment. For example, we saw a risk assessment and a management plan for the risk of social isolation for one person who lived alone. Also, a risk assessment and management plan for a person who spent most of the day sitting in the same position and was at risk of developing pressure sores. Staff were aware of the risks the people they supported faced and how to manage these risks.

We did not review the action the provider took in response to accidents because the provider told us there had been no accidents reported in the last 12 months. However, we saw evidence that there was a system in place to record accidents.

People were protected from the risk and spread of infection. Staff had received training in infection control and had an ample supply of personal protective equipment such as disposable gloves and aprons.

Good

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At our previous inspection we found that people were not always cared for by the provider in line with the MCA.

During this inspection we found that the registered manager and some staff had received training in the MCA. The staff we spoke with had good knowledge of the main principles of the MCA. 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There is a separate process for services such as Alma Care UK which support people in their own homes.

At our last inspection the registered manager was unsure of the process to follow if a person lacked capacity. During this inspection the provider had established a process; people's capacity to make certain decisions had been assessed. Where people lacked capacity to make any decisions their care files contained details of the person who had the legal authority to make decisions on their behalf. This information had been verified by the provider.

People told us staff sought their consent before supporting them. People told us, "They never do anything without asking me first" and "The carers do as I ask." A member of staff told us, "I always tell people what I am going to do and ask if it's ok. If they say no I have to listen to them" and "I listen to what people want. Even though I'm there to give someone a shower if they don't want one that day I can't force them."

People continued to be supported by staff who received induction, training, supervision and annual appraisal from the provider. New staff received a three day induction during which they were trained in a range of topics relevant to their role, such as moving and handling, safeguarding adults at risk and health and safety. The provider ensured new staff shadowed more experienced staff before they provided care to people alone. New staff also completed the Care Certificate. The Care Certificate is a national qualification developed to provide structured and consistent learning to ensure that care workers have the same introductory skills, knowledge and behaviours to provide safe, good quality care and support. This meant staff were reaching the expected standards of care workers during their induction period.

People's needs and preferences were assessed before they began to use the service. The provider met with people and where appropriate their relatives to discuss people's physical, mental health and social needs. People told us staff supported them to prepare and cook food when this was needed. One person said, "I have plenty to eat and drink my carers make sure of that." Staff told us they were aware of people's individual likes and preferences in relation to food and drink and said they encouraged people as far as possible to have a balanced diet. Although there was no one currently using the service whose dietary intake

was being monitored; staff told us if they saw people were struggling to maintain a healthy diet they would monitor their intake. They would then use this information to alert healthcare professionals to seek additional advice to maintain a person's health.

People told us staff were observant to any changes in their health and where required staff supported people to access healthcare services. One member of staff said, "You get to know people very well. If I am concerned about a person's health I would speak with the person, or their family and if necessary [healthcare] services." People's records showed action had been taken to involve external healthcare professionals. This showed people's health needs were monitored and that people were supported to access healthcare services when required.

Requires Improvement

Is the service caring?

Our findings

Staff were caring. However, the provider did not know how many people were using the service. This meant the provider did not have sufficient oversight of the service for us to be assured that the service was caring. Consequently, although we found no breaches under this key question, improvement is required.

People made positive comments about the care workers who supported them. Person told us their care workers were, "Nice", "Considerate" "Jolly and willing." Relatives told us, "I'm very happy with [carer's name]. I think she is genuinely caring and tries her best", "I'm happy with the current carers because I know [the person] is comfortable with them" and "The carer gets on very well with [the person]. She doesn't just come in a do what she has to do, they have a chat and I know [the person] appreciates that."

People were supported by a consistent staff team and regularly received care from the same care worker. This helped staff to establish meaningful relationships. Staff knew people well and were able to tell us the specific support people required and how each person communicated their choices. One person told us, "I always have the same person unless they off." A relative told us, "We like that we usually have the same person coming in. We've got a nice routine. I know that [the person] would find it confusing if there were different people coming in all the time."

People were supported to maintain their independence. Staff told us they encouraged people to continue to do as much for themselves as possible for as long as they were able. Staff commented, "When I am helping someone to get washed and dressed if there are certain things they can do for themselves I encourage them to do it", "It's important you know the people you are working with. When they want to help themselves I only step in when if think they can't manage."

People told us staff protected their dignity when providing care or support. One person said, "I am treated with the respect my carers." Another person told us, "I couldn't be treated with more respect. I'm so lucky to be cared for by such lovely people." Staff told us they ensured people were comfortable and happy with the way care was being provided. They were able to provide us with examples of what this meant in practice. For example, one member of staff said, "I always explain what I am doing. If it is personal care I make sure [Person's name] is happy, that I have everything close by and the door is closed to protect [Person's name] privacy."

The provider ensured staff completed equality and diversity training in order to improve their understanding of people's legal rights. Staff told us, "We have to know how to treat people from different backgrounds and understand their culture" and "It's important that we treat people equally."

Good

Is the service responsive?

Our findings

At our last inspection, we found that the service was not always responsive to people's needs. This was because people were not always involved in developing and reviewing their care plans; the provider did not have effective systems to gather feedback from people and the provider's complaints policy was misleading.

Since our last inspection, the provider had reviewed and re-assessed people's needs. People's care plans contained personalised information about how they preferred their care to be provided. The care plans we had access to had details of how people preferred their personal care to be delivered, who else was involved in their care, details of their health diagnosis, the medicines required as well as details of how people spent their day and where they liked to go. People told us they had been involved in their care planning and that the care they received reflected their preferences.

The provider had improved the arrangements in relation to obtaining feedback from people and was now using this information to improve the service. A care manager conducted spot checks on staff every three months. Records indicated that during spot checks issues such as whether staff were using PPE and practising good hand hygiene was checked, as well as staff punctuality and whether they were wearing their uniform and identification. The care manager used these visits as an opportunity to obtain people's feedback on the care they received.

After our previous inspection, the provider had sent a feedback survey to people using the service and relatives who were involved in their care. The results we saw were mainly positive and included comments such as, "[Staff name] is an excellent care worker, she is kind, patient and caring." Where negative feedback was received, the person was visited to discuss their concerns and action was taken to address their concerns. For example, one person's feedback stated that they were not always notified if their carer was going to be late. Records indicated that the person was visited and their concerns discussed in more detail. After the inspection the person told us that staff punctuality had improved and there was no longer a need to be notified that staff were going to be late.

The provider had systems in place to record, investigate and respond to complaints. People told us they knew how to make a complaint. One relative told us that they had made a complaint to the office and that the care their loved one received had improved. However, another relative told us "I've had to ring the office three or four times when I want to discuss [relative's name] care and they never got back to me. In the end I just sorted it out with the carer."

The provider summarised the complaints policy in the 'service user handbook' people were provided with when they began using the service. Since our previous inspection, the provider's complaints policy had been amended and updated. The new policy gave people correct information on the organisations to contact in the event that they were dissatisfied with the response to their complaint.

People were satisfied with the care they received. They commented, "I'm happy enough with them. They are polite and get on with the job" and "They are pretty good." Although two relatives said that the service had

only recently began to improve and they were waiting to see if the improvement would be sustained. They commented, "Things have got much better recently but I'm not sure if that will last" and "I'm happy with the carer now she knows how to do things. I think she's lovely but I haven't got much confidence in the agency itself."

Inadequate

Is the service well-led?

Our findings

People were supported by a service which was not well-led. At our last inspection we found the provider had minimal quality assurance processes in place to monitor, assess and improve the service. During this inspection, we found the provider's quality assurance processes were not as effective as they needed to be to ensure that people received safe care and that the provider had oversight of the care people received.

During the inspection the registered manager told us that nine people were using the service and receiving personal care. After the inspection, we spoke to staff, and representatives of a local authority which commissions the service. The information they gave us indicated that there more people using the service than we had been told by the registered manager. We wrote to the provider five times to ask them to check their records and confirm the number of people using the service at the time of our inspection. On each occasion the number of people the provider told us were using the service was incorrect. The provider then wrote to a local authority to ask for the names of people the local authority knew was using the service. This meant that the provider did not know exactly who they were meant to be providing care to. Additionally, the provider did not have a system in place which enabled staff to know who was using the service; or to assess and monitor the care the every person using was receiving. This meant there was a risk that people who required care were not receiving it and there was a risk of people receiving poor care because of insufficient processes to audit the service.

The registered manager told us that people's MAR were returned to the office at regular intervals so that the care co-ordinator could check that people were receiving their medicines as prescribed. We asked the registered manager how often the MAR were returned to the office. The registered manager did not know how often the MAR charts should be returned and the provider did not have a policy which covered this. When we asked for the MAR for the one person who the registered manager told us staff assisted with their medicines, we were handed one sheet which was undated. We asked the registered manager what period this sheet covered and she did not know. We asked the registered manager for the other MAR charts relating to this person. The care co-ordinator told us that she or the care manager checked the person's MAR when they conducted spot checks. However, neither the registered manager or care co-ordinator were able to provide any evidence of these checks.
The care co-ordinator then told us that these were the only MAR available as staff had only just started to administer medicines to this person. We were able to confirm with the local authority that staff had supported this person to take their medicines since September 2016.

The provider's lack of effective systems to assess and monitor the quality of care people received meant that the provider had not identified the issues we identified during our inspection. These issues amount to a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We have sent the provider a requirement letter. This means the provider is required under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provide us with information we have requested relating to the safety of people using the service.

At our previous inspection we found that the provider did not always send notifications about significant events to CQC as required by law. After the inspection, the registered manager was reminded they had a legal obligation to notify the CQC without delay about certain incidents which had adversely affected the health, safety and well-being of people using the service. During this inspection the registered manager told us there had been no notifiable events since our last inspection. However, when we contacted a representative of the local authority which commissions the service they told us there had been an allegation of abuse in April 2018. The provider did not notify the CQC about this allegation of abuse as required by law. This meant the CQC did not have oversight of and could not fully monitor any risks associated with the service.

The provider's failure to submit a statutory notification regarding an allegation of abuse is a repeated breach of Care Quality Commission (Registration) Regulations 18 (Notifications of other incidents) 2009.

We received mixed feedback on whether the service was well-led. People commented, "As far as I know they appear to be quite organised. The carer turns up when he should", "I think it is managed ok", "I have no problem with the carers, it's the administration. It's impossible to get hold of people in the office and when you do they don't seem to know what's going on" and "The office staff don't seem on top of things."

Staff felt well supported and enjoyed working for the provider who involved staff in developing the service. The provider held staff meetings once a year or more often if necessary. These were usually held in restaurants to encourage staff to attend to share their views. Staff told us the provider updated them on any service developments and they were able to share any ideas to improve the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Care Quality Commission of any abuse or allegation of abuse in relation to a service user.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not provide care and treatment to service users in a safe way; medicines were not always managed properly and safely. Regulation 12(1) and (2) (g).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not establish and operate effective systems to assess, monitor and improve the quality of the service. Regulation 17(1) and (2)(a).

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not ensure that persons employed were of good character.

Regulation 19 (1) (a).