

Lanh Professionals LLP

LANH

Inspection report

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24 April 2018

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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?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection was carried out on 24 April 2018, and was an announced inspection. The provider was given 24 hours' notice of the inspection as we needed to be sure that the office was open and staff would be available to speak with us.

LANH is a domiciliary care agency registered to provide personal care for people who require support in their own home. 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. This was the first comprehensive inspection since the agency was registered on 16 June 2017. At the time of our inspection, they were supporting two people who received support with personal care tasks. One person was in hospital at the time of the inspection visit. Both people were private clients.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The provider did not have adequate processes in place to monitor the delivery of the service.

The provider had not carried out appropriate individual risk assessments when they visited people for the first time. There were no care related risk assessments identified for people's specific health and care needs, their mental health needs, medicines management, and any equipment needed. We have made a recommendation about this.

Relatives told us that the provider's telephone number on their website was unobtainable. We have made a recommendation about this.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The provider understood their responsibilities under the Deprivation of Liberty Safeguards. People's capacity to consent to care and support had been assessed and recorded within their care plans.

Staff had received training as is necessary to enable them to carry out the duties they are employed to perform. All staff received induction training at start of their employment. Refresher training was provided at regular intervals.

People's needs had not been properly assessed by LANH prior to receiving support from the service. Care plans had been developed with people by LANH on how to meet their needs.

The provider had followed effective recruitment procedures to check that potential staff employed were of good character and had the skills and experience needed to carry out their roles.

Medicines were managed safely and people received them as prescribed. However, medicine audits had not been undertaken.

The provider had suitable processes in place to safeguard people from different forms of abuse. The registered manager knew what their responsibilities were in relation to keeping people safe from the risk of abuse. The registered manager recognised the signs of abuse and what to look out for. There were systems in place to support staff and people to stay safe.

The provider provided sufficient numbers of staff to meet people's needs and provide a flexible service.

People were supported with meal planning, preparation, eating and drinking. Staff supported people, by contacting the office to alert the provider to any identified health needs so that their doctor or nurse could be informed.

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

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 consistently safe.

People were not always protected from the potential risk of harm.

Medicines were managed in a safe way. Staff had been adequately trained in medicine administration.

The provider had always followed safe recruitment practices.

There were enough staff available to meet people's needs.

Staff knew how to recognise any potential abuse and so help keep people safe.

Is the service effective?

Good 

The service was effective.

People's human and legal rights were respected by staff. Staff had the knowledge of the Deprivation of Liberty Safeguards and Mental Capacity Act (2005). MCA assessments were carried out to ascertain capacity of people receiving care and support.

Staff received on-going training in areas identified by the provider as key areas.

People were supported to be able to eat and drink sufficient amounts to meet their needs.

Staff were knowledgeable about people's health needs, and contacted other health and social care professionals if they had concerns about people's health.

Is the service caring?

Good 

The service was caring.

Relatives felt that staff provided good quality care.

Staff protected people's privacy and dignity, and encouraged

them to retain their independence where possible.

Wherever possible, people were involved in making decisions about their care and staff took account of their individual needs and preferences.

Is the service responsive?

Good ●

The service was responsive.

People's care plans reflected their care needs.

Staff were informed about the people's needs before service started.

People felt comfortable in raising any concerns or complaints and knew these would be taken seriously.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

Quality assurance systems had not been implemented effectively or embedded to improve the quality of the service people received.

The registered manager was aware of their responsibilities.

Relatives felt the service was well managed and would listen to any concerns.

LANH

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.

The inspection took place on 24 April 2018 and was announced. The provider was given 24 hours' notice of the inspection as we needed to be sure that the office was open and staff would be available to speak with us.

The inspection was carried out by one inspector who visited the agency's office in Dartford area of Kent and an expert-by-experience, who made calls to people using the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience for this inspection had experience in care for older people.

Prior to the inspection, we looked at information we held about the agency, such as, notifications. Notifications are changes, events or incidents which the provider is required to tell us by law. We used all this information to plan our inspection.

As part of the inspection, we spoke with the management of LANH, which included the nominated individual and the registered manager. Both the nominated individual and the registered manager have many years of experience working within Health and Social care sectors as registered nurses. We also spoke with one relative of people who used the service. We tried speaking with the only member of staff supporting one person on the telephone but their phone number was always unavailable.

During the inspection visit, we reviewed a variety of documents. These included two people's care records, which included care plans, health care notes, risk assessments and daily records. We also looked at three staff recruitment files, records relating to the management of the service, such as staff training plan, audits, satisfaction surveys, staff rotas, policies and procedures.

We asked the registered manager to send additional information after the inspection visit, which we found

missing from the staff records and care records. The information we requested was sent to us in a timely manner.

Is the service safe?

Our findings

A relative spoken with on the phone felt satisfied with the care their relative received from the service. They said, "Yes, I would say my mum is safe".

Before any care package commenced, the registered manager told us they carried out risk assessments. We were shown an environmental risk assessment form just implemented, which confirmed this. The comprehensive environmental risk assessments of the person's home was undertaken to make sure it was a safe environment for staff to work in. However, we found that people did not always have individual risk assessments about action to take to minimise the chance of harm occurring or eliminating any identified risk in a risk assessment. Further, the information documented was contradictory. For example, one person had restricted mobility and information was provided to staff about how to support them when moving around their home in the care plan. The risk assessment we saw used a scoring system, which had been scored as a total of 13. At the bottom of the risk assessment it stated, 'Service user with score of below 13 are at risk'. The care plan stated, 'Leaves her walking sticks and Zimmer frame on the floor and can cause falls. Needs reminding time and again'. There were no moving and handling risk assessment and comprehensive falls risk assessment to help guide staff reduce identified risks. This showed that the person was at risk of falls, with no supporting appropriate risk assessment to adequately mitigate any associated risk.

We recommend that the provider seek guidance on the implementation of comprehensive risk assessments to mitigate risk to people who use the service.

We checked the service's accidents or incidents records and found that there had not been any incidents since the service started. The registered manager told us that accidents and incidents would be recorded by staff and reviewed by them so that they could assess if there was any action that could be taken to prevent further occurrences and to keep people safe.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Appropriate checks were undertaken and enhanced Disclosure and Barring Service (DBS) checks had been completed. The DBS checks ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks had been completed. Staff we spoke with and the staff files that we viewed confirmed this. The provider also had an effective system in place to check that staff's own car used for the business were appropriately insured and had a current ministry of transport (MOT) test certificate as they used them as part of their day to day work. We found up to date records of staff car insurance and driving licence which had been checked by the registered manager were in place. This meant that people could be confident that they were cared for by staff who were safe to work with them.

Employment procedures were carried out in accordance with equal opportunities. Interview records were maintained and showed the process was thorough, and applicants were provided with a job description. Successful applicants were provided with the terms and conditions of employment.

Management spoken with were aware of how to protect people from abuse and the action to take if they had any suspicion of abuse. They were able to tell us the different types of abuse and how to recognise potential signs of abuse. Staff training in protecting people from abuse commenced at induction, and there was on-going refresher training for safeguarding people from abuse. Management and staff had completed safeguarding training. The registered manager was able to discuss the appropriate actions to be taken if abuse was suspected, and they were able to demonstrate how they would ensure the person's safety was maintained. They said, "Safeguarding is about raising any suspected concerns. If I have a concern I would report it to the local authority and notify CQC". This showed that the registered manager was knowledgeable about safeguarding, which would enable them to keep people safe from the likelihood of abuse. Staff also had access to the updated local authority safeguarding policy, protocol and procedure, which was in the office. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. The registered manager understood what whistle blowing is about. Whistleblowing occurs when an individual raises concerns, usually to their employer or a regulator, about a workplace wrongdoing or illegality that affects others. They were confident about raising any concerns with the provider or outside agencies if this was needed.

Staff were trained to assist people with their medicines where this was needed. Checks were carried out to ensure that medicines were stored appropriately, and care staff signed medicines administration records for any item they assisted people to take. Recording in the care plan when they had prompted someone to take their medicines. Care staff were informed about action to take if people refused to take their medicines. Both the registered manager and the nominated individual were nurses with in date Nursing and Midwifery Council (NMC) PIN numbers.

Staffing levels were provided in line with the support hours agreed with the person receiving the service. The registered manager said that staffing levels were determined by the assessed needs when they accepted to provide the service and also whenever a review took place. Currently there were enough staff to cover all calls and staff numbers are planned in accordance with people's needs. Therefore, staffing levels could be adjusted according to the needs of people, and the number of staff supporting a person could be increased if required. The registered manager told us that they carried out visits to people whenever required to ensure their staffing needs are met.

Staff had received infection control training. We saw that the registered manager had a good supply of personal protection equipment and showed they knew how important it is to protect people from cross infection. Staff were provided with appropriate equipment to carry out their roles safely. For example, they were issued with gloves, aprons and hand gel. There was a stock of personal protective equipment (PPE) kept in the office which staff could access regularly to stock up.

The registered manager told us they were always on call and would be available if staff needed help or support. A relative said, "The number on their website is unobtainable". We tried phoning the number on the website a couple of times after we received the feedback and found that it was always going to a voicemail. This confirmed that it might not always be possible for people to be able to make contact with the provider whenever necessary.

We recommend that the provider seek advice and guidance about making themselves available to people who use the service at all times particularly during emergencies.

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. 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. The procedure for this in community settings is via application to the Court of Protection.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) which included steps that staff should take to comply with legal requirements. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. All staff had received training on the application and awareness of the Mental Capacity Act 2005. This enabled staff to understand issues around MCA and consent issues. People's care plans contained a section about consent, which people agreed with. The Mental Capacity Act aims to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision making.

People's capacity to consent to care and support had been assessed and recorded within their care plans. Where people lacked capacity to make specific decisions; the registered manager had a good understanding of what procedures to follow.

Staff had received induction training, which provided them with essential information about their duties and job roles. The registered manager told us that staff completed their in house induction before starting to work in the community. The induction and refresher training included privacy and dignity, confidentiality and data protection. The registered manager told us that any new staff would normally shadow experienced staff, and not work on their own until assessed as competent to do so.

Staff had received some training to support them in their roles. The staff training records showed that all staff had attended safeguarding adults, moving and handling, dementia awareness, infection control and first aid training. We saw training certificates in staff files which confirmed this.

Staff were matched to the people they were supporting as far as possible, so that they could relate well to each other. The registered manager introduced care staff to people, and explained how many staff were allocated to them. People got to know the same care staff who would be supporting them. This allowed for consistency of staffing, and cover from staff that people knew in the event of staff leave or sickness.

People's needs with regards to eating and drinking varied. Some people got their own meals and for other people they were provided by relatives or another service. The level of support people required was recorded in their care plans. When staff prepared meals for people, they consulted people's care plans and were aware of people's allergies, preferences and likes and dislikes. People were involved in decisions about what to eat and drink as staff offered options. Staff were aware of people's nutrition, hydration and special

diet needs. A record was made of what people ate and drank.

People were involved in the regular monitoring of their health. Care staff identified any concerns about people's health to the registered manager, who then contacted their GP, community nurse, mental health team or other health professionals. For example, one person went into the hospital while the care staff was visiting and the relative wrote to the registered manager, 'I must thank 'X' [staff member] for their fabulous care today. They were so kind and patient with mum'. Each person had a record of their medical history in their care plan, and details of their health needs. Records showed that the registered manager worked closely with health professionals such as district nurses in regards to people's health needs. This included staff applying skin creams, recognising breathing difficulties, pain relief, care and mental health concerns.

Is the service caring?

Our findings

A relative said, "I think the way they care for her, yes very caring, If mum said can you do this they will say yes, even feed the cat".

People were involved in their care planning and their care was flexible. People's care plans detailed basic information about what type of care and support they needed in order to maintain their independence and reach goals to improve their lives. The daily records showed staff had delivered the care in their care plan. They had been flexible and staff had actively encouraged independence and choices. Staff were aware of the need to respect choices and involve people in making decisions where possible. The registered manager told us they ensured people's choices were respected.

Relatives told us that staff were clear on how to maintain people's dignity when supporting them with their personal care. When asked, 'Did you feel your relative was treated with respect and dignity? The relative said, "Oh yes, absolutely, 100%". The registered manager had a good rapport with people and knew people well. The registered manager was able to describe people's care routines, likes and dislikes.

The registered manager and staff had a good understanding of the need to maintain confidentiality. People's information was treated confidentially. Personal records other than the ones available in people's homes were stored securely in the registered office. People's individual care records were stored in lockable cupboards. Staff files and other records were securely locked in cabinets within the office to ensure that they were only accessible to those authorised to view them.

The service had reliable procedures in place to keep people informed of any changes. The registered manager told us that communication with people and their relatives, staff, health and social care professionals was a key for them in providing good care. The registered manager told us that people were informed if their regular carer was off sick, and which staff would replace them. People said that when they first started to use the service, it was explained to them that although they were given an exact time when their staff would arrive at their home. People confirmed to us that if staff were running late, the registered manager do inform them.

The relative spoken with felt staff had a good understanding of their care needs. Daily records of the care and support delivered were kept in a folder in people's homes. We viewed the daily records for one person which showed the care staff delivered. We found these were kept up to date.

Is the service responsive?

Our findings

A relative said, "I was given a booklet when the service started. I must admit I haven't read it all. I think if I had concerns I would tell them".

Assessments of people's needs were undertaken by the registered manager to make sure care delivered was effective and achieved good outcomes for people. The registered manager told us that they carried out people's needs and risk assessments before the care began. They told us that they discussed the length of the visits that people required, and this was recorded in their care plans. Such tasks included care tasks such as washing and dressing, helping people to shower, preparing breakfast or lunch, giving drinks and turning people in bed. These were reviewed as and when necessary for example if people's needs changed. The staff knew each person well enough to respond appropriately to their needs in a way they preferred and support was consistent with their plan of care.

Staff were informed about the people they supported as the care plans contained information about their backgrounds, family life, previous occupation, preferences, hobbies and interests. The care plans included details of people's religious and cultural needs. The registered manager matched staff to people after considering the staff's skills and experience. Care plans detailed if one or two care staff were allocated to the person, and itemised each task in order, with people's exact requirements. This was particularly helpful for care staff assisting new people, or for care staff covering for others while on leave, when they knew the person less well than other people they supported, although they had been introduced.

People were given a copy of the service's complaints procedure, which was included in the service users' guide. The information included contact details for the provider's head office, social services, local government ombudsman and the Care Quality Commission (CQC). People told us they would have no hesitation in contacting the registered manager if they had any concerns, or would speak to their care staff.

The registered manager dealt with any issues as soon as possible, so that people felt secure in knowing they were listened to, and action was taken in response to their concerns. The registered manager visited people in their homes to discuss any issues that they could not easily deal with by phone. They said face to face contact with people was really important to obtain the full details of their concerns. We reviewed how the provider handled complaints received and found that there had been no complaints made since the service started.

LANH provided care and support to people to enable them to maintain their independence and live in their own homes. During this visit, the service did not provide care and support to people who were at the end stages of life.

Is the service well-led?

Our findings

When asked, 'Do you feel the service is well managed /well led? A relative said, "I think it's well managed".

The service did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided. Audits of daily communication records and MAR charts were not undertaken. There were no audits of calls times carried out to ensure that people were getting the care and support they were assessed for. There were no comparisons made of planned and actual delivered hours of care. Visit log books had never been audited in line with call times. Staff files were not being audited. We spoke with the registered manager to ask whether there were any records of audits and checks to evidence that they were monitoring the service and they told us that this was being implemented. Checks were not being carried out to ensure that medicines were administered appropriately, and that care staff signed medicines administration records for any item they assisted people to take. This meant that there had not been a robust monitoring system in place since the coordinator left.

The registered managers failed to operate an effective quality assurance system to ensure they assess, monitor and improve the quality and safety of the services provided. This is a breach of Regulation 17 (1) (2) (a) (b) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

There was a registered manager at the service. 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.

The aims of the service were clearly set out on their website. It stated, 'We are aiming to work with everyone and ensuring that patients care comes first'. We found that the organisational values had been discussed with staff, and reviewed to see that they remained the same and in practice. Our discussions with the registered manager and the nominated individual when we inspected showed us that there was an open and positive culture that focused on people.

There were a range of policies and procedures governing how the service needed to be run. The registered manager followed these in liaising with outside agencies. The registered manager kept staff up to date with new developments in social care. All staff had been given an up to date handbook which gave staff instant access to information they may need including policies and procedures.

Communication in the service had been improved through handovers with on-call staff and regular office meetings. There was also a meeting of the management team. At these meetings, any concerns, actions or issues were discussed and addressed. These meetings enabled issues to be raised and resolved. For example, a team meeting held on 20 March 2018 identified improvement plans were needed regarding care plans. This had been inserted into the 2018 – 2019 service improvement plan with set dates for this to be achieved alongside who was responsible. We found that this had been achieved when we inspected.

Feedback from people about the quality of the service was undertaken through a telephone service user questionnaire. The results of the questionnaire carried out in April 2018 showed that the person receiving the care and support was satisfied with the service they received from LANH. A relative commented, 'LANH have been caring for my mother since September 2017 and I am very pleased with the service. The carers are lovely ladies and very friendly. Each visit is well documented and records kept for ease of tracking. Mum has a dossett box for medicine which is working well, and again records are well maintained. I am kept informed of any concerns for peace of mind and detailed invoices are sent regularly. I can recommend LANH Professionals to others looking for care at home. I could not manage without them!'

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the service. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered manager confirmed that no incidents had met the threshold for Duty of Candour. This demonstrated the registered manager understood their legal obligations.

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 17 HSCA RA Regulations 2014 Good governance The registered manager failed to operate effective quality monitoring systems. Regulation 17 (1)(2)(a)(b)(d)