Jasmine Care (South East) Limited

Jasmine Care South East Limited

Inspection report

17 Brooker Close
Boughton Monchelsea
Maidstone
Kent
ME17 4UY

Tel: 01580713533

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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 announced and carried out on 27 and 29 June 2018.

Jasmine Care South East 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' and 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 with us as a limited company on 24 January 2017. The provider had another location registered with us, that they were closing down as they had downsized the business and were in the process of transferring all documentation to this location. At the time of our inspection, they were supporting 11 people.

The provider had not at the time of the inspection, amended and re-submitted her application to become the registered manager of 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 provider had failed to have a registered manager in place. This was a breach of section 22 of the Health and Social Care Act 2008.

The provider was currently putting processes in place to monitor the delivery of the service with the support of an external consultant. However, quality assurance auditing had not as yet been implemented. We made a recommendation about this.

The provider had suitable processes in place to safeguard people from different forms of abuse. However, the provider needed to update their copy of the local authority safeguarding documentation. We made a recommendation about this.

There was no risk assessment in place in relation to the taking of the medicine 'Warfarin' and any side effects staff should look out for. We made a recommendation about this.

The provider followed recruitment procedures to check that potential staff employed were of good character and had the skills and experience needed to carry out their roles. However, they were reminded about obtaining satisfactory references in line with their employment policy. We have made a recommendation about this.

The provider and staff knew what their responsibilities were in relation to keeping people safe from the risk of abuse. The provider 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 assessed people's needs on their first visit to the person, and then by asking people if they were happy with the care they received. People were supported to plan their support and they received a service that was based on their personal needs and wishes, however records of support required needed to be more comprehensive. The service was flexible and responded positively to changes in people's needs. Some people were supported by their family members to discuss their care needs, if this was their choice to do so. People were able to express their opinions and views and they were encouraged and supported to have their voices heard.

People told us they were treated with dignity and respect by staff who were polite and caring. They told us that staff verbally asked for their consent before undertaking any personal care.

People were supported with meal planning, preparation, eating and drinking when required. 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.

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

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 the start of their employment. Refresher training was provided at regular intervals.

Staff followed an up to date medicines policy recently issued by the provider and they were checked against this and assessed by the provider. Staff were trained to meet people's needs and were now supported through regular supervision and an annual appraisal so they were supported to carry out their roles.

People said that they knew they could contact the provider at any time, and they felt confident about raising any concerns or other issues. As well as talking to the provider at spot checks, people could phone the office at any time. People's views were obtained through meetings with the person and meetings with families of people who used the service. The provider checked how well people felt the service was meeting their needs. Suitable arrangements had been made to enable the service to learn, improve and assure its sustainability by ensuring that all regulatory requirements were met. The service worked in partnership with other agencies to enable people to receive 'joined-up' care.

Management systems were in use to minimise the risks from the spread of infection, staff received training about controlling infection and had access to personal protective equipment like disposable gloves and apron's.

Working in community settings staff often had to work on their own, but they were provided with good support and an 'Outside Office Hours' number to call during evenings and at weekends if they had concerns about people. The service could continue to run in the event of emergencies arising so that people's care would continue.

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.

General and individual health and risks were recognised but not always recorded

People experienced a service that made them feel safe. Staff knew what they should do to identify and raise safeguarding concerns.

Staffing levels were flexible and determined by people's needs. Recruitment procedures aimed to make sure people were only supported by staff that had been deemed suitable and safe to work with them.

Systems were in place so that medicines were administered safely.

Is the service effective?

Good

The service was effective.

People's needs were assessed.

People were cared for by staff who knew their needs well.

Staff encouraged people to eat and drink enough.

Staff met with the provider to discuss their work performance. Staff received on-going training and regular supervision.

The Mental Capacity Act 2005 was understood by the provider and staff received training about this.

Is the service caring?

Good

The service was caring.

People had good relationships with staff so that they were

comfortable and felt well treated.

People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

People were treated with dignity and respect. Staff understood how to maintain people's privacy.

Is the service responsive?

Good

The service was responsive.

People received care that was based on their needs and preferences. They were involved in all aspects of their care and were supported to lead their lives in the way they wished to.

The service was flexible and responded quickly to people's changing needs or wishes.

Information about people was updated with their involvement so that staff were aware of people's current needs.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not had her application to be the registered manager accepted, as the application needed amending and had not been re-submitted.

The provider had not implemented the quality assurance and monitoring procedures, in order to provide an on-going assessment of how the service was functioning; and to act on the results to bring about improved services.

There were structures in place to monitor and review the risks that may present themselves as the service was delivered.

There was an open and positive culture which focused on people. The provider sought people and staff's feedback.

Jasmine Care South East Limited

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 27 and 29 June 2018 and was announced. The provider was given six days' notice of the inspection, following cancellation on the day of the previously agreed inspection date by the provider, as we needed to be sure that the office was open and the provider would be available to speak with us. The inspection team consisted of one inspector and one expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also 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.

We spoke with the provider and one member of the three staff who provided care to people living in the community. We telephoned and spoke with four people and two relatives of people that used the service.

We looked at records held by the provider. This included three care plans, daily notes; a range of the providers policies including safeguarding, medicines and the complaints policy; the recruitment and training records of staff employed and the new auditing documentation provided by the external consultant.

This was the first inspection of Jasmine Care South East, since it was registered with us as a limited company in January 2017.

Requires Improvement

Is the service safe?

Our findings

People described a service that was safe and said they felt safe receiving care from the staff. They told us that they felt safe with the staff that visited them in their own home and had no cause for concern regarding their safety or the manner in which they were treated by staff. One person said, "I usually see the same carers which I like as we have the continuity". One relative said, "Yes, she has mainly regular ones (staff), and the manager comes out and delivers care as well".

The service had a policy for safeguarding adults from harm and abuse. However, the copy of the Local Authority safeguarding procedure seen needed updating and the provider said she would address this issue. Staff had information about preventing abuse, recognising the signs of abuse and how to report it. It also included contact details for other organisations that can provide advice and support. Staff had received training in safeguarding and the provider checked their understanding of the policy at meetings and one to one discussions. Staff we spoke with understood what action they needed to take to keep people safe. Staff told us they were confident to report abuse to management or outside agencies, if this was needed. Staff also knew how to blow the whistle on poor practice to agencies outside the organisation. This meant that staff knew how to protect people from the risks of harm and abuse.

We recommend that the provider obtains up to date information about the Local Authority Safeguarding protocol and procedures.

The risks involved in delivering people's care had been assessed to keep people safe. Before any support package was commenced, the provider carried out risk assessments of the environment, and for the care and health needs of the person concerned. Environmental risk assessments were undertaken, and included risks inside and outside the person's home. For example, checks for gas, electric, and checks on the outside of the premises. Risk assessments for inside the property highlighted, if there were any obstacles in corridors and if there were pets in the property.

People's individual risk assessments included information about action to take to minimise the chance of harm occurring. For example, some people had restricted mobility and information was provided to staff about how to support them when moving around their home. In this way people were supported safely because staff understood the risk assessments and the action they needed to take when caring for people. For one person whose information stated that they were taking the medicine 'Warfarin' (an anticoagulant drug take to prevent the blood from clotting, reducing the risks of clots causing strokes and heart attacks), there was no risk assessment in place and no information for staff to follow should they notice any changes in skin condition, for example bruising that would need to be reported.

We recommend that all risk assessments are recorded to meet the needs of each individual person and to support staff in providing care for the person.

People were supported to manage their medicines safely and at the time they needed them. Checks were carried out to ensure that medicines were stored appropriately, and support staff signed medicines

administration records for any item when they assisted people. Staff had been trained to administer medicines to people safely. Staff were informed about action to take if people refused to take their medicines, or if there were any errors. Records showed that people received the medicines they needed at the correct time. One person said, "Oh yes, she (staff) gives me my tablets and I take them before she goes". One staff member told us, "I complete the medication administration record (MAR), when I have supported the person to take their medicine in the morning".

Staff knew how to inform the office of any accidents or incidents. They said they would contact the office and complete an incident form after dealing with the situation. As the service is currently small the provider said that there had been no accidents or incidents to date. They said they would view any accident or incident report, so that they could assess if there was any action that could be taken to prevent further occurrences and to keep people safe.

Staffing levels were provided in line with the support hours agreed with the person and determined by the number of people using the service and their needs. Currently there were enough staff to cover all calls and staffing numbers were 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 as required.

We looked at staff recruitment practices, to check that staff were suitable to work with people in their own homes. We looked at one staff file of a person that had worked at the service for some time. This contained all appropriate information other than a contract of employment. The provider said that this information was held at the other office location (currently in the process of closing). The provider was able to show evidence of this contract on the second day of the inspection.
We looked at files for two people that were about to start employment at the service. We discussed with the provider that for one person the provider did not have a previous employer reference and that one of the two personal references provided was from a person who had only known the person for one month. All three files we looked at included Disclosure and Barring Service (DBS) checks before successful recruitment was confirmed. DBS checks identify if prospective staff have had a criminal record or have been barred from working with children or vulnerable people.

We recommend that the provider follows their own recruitment policy and obtains satisfactory references for people they wish to employ.

Staff had received infection control training. The provider had a supply of personal protection equipment and 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 and aprons.

The provider planned in advance to ensure people's care could be delivered. The provider had policies about protecting people from the risk of service failure due to foreseeable emergencies so that their care could continue. The provider had an out of hours on call system, which enabled serious incidents affecting peoples care to be dealt with at any time should they arise.

Good

Is the service effective?

Our findings

People told us staff were well-trained and attentive to their needs. Feedback from people was positive. One person said, "Most of them seem to know what they are doing, but we have had one or two in the past who did not seem to know and did not appear well trained, but after I complained they did not return".

There was an initial assessment process undertaken by the provider before the service started. The assessment captured the care and support needs of each person so the provider could make sure staff had the skills to care for the person appropriately. At the assessment stage people were encouraged to discuss their sexuality or lifestyle preferences as well as their rights, consent and capacity. The provider kept people's dependency levels under review to capture changes in people's care needs and levels independence. This meant that more staff hours could be deployed if people's needs increased for short periods. The assessment processes involved people and their family members in the assessment process when this was appropriate.

The initial needs assessment led to the development of the care plan. Individual care plans informed staff on how to support people in the way they wanted. Staff were required to record the care they had provided to people by recording how they had met people's needs in their care plan records. People's health and wellbeing was consistently monitored and reviewed in partnership with external health services.

People benefited from consistent staff who got to know their needs well. People told us they had regular carers, whom they knew well and people said they got on well with the carers that visited them. We were told that people can always contact the office and discuss the support that was needed. People's needs were assessed, recorded and communicated to staff effectively. The staff followed specific instructions to meet individual needs. One person said, "We have a system at night, they get me ready for bed, soak my feet. It is not my choice to go to bed that early so they make me comfortable in the chair and check I am OK before they go".

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 lest 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. Staff understood and had a good working knowledge of the key requirements of the Mental Capacity Act 2005. They put these into practice and ensured people's human and legal rights were respected. The staff had a clear understanding of people's rights in relation to staff entering their own homes.

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 provider had an understanding of what procedures to follow. People were always asked to give their consent to their care, treatment and support. Records showed that staff had considered people's capacity to make particular decisions and knew what

they needed to do to ensure decisions were taken in people's best interests, with the involvement of the right professionals.

People's care was planned and delivered to maintain their health and well-being. People were supported to maintain a balanced diet when required. Care records evidenced the care and support needs that people had in relation to maintaining their health through eating and drinking. Care plans encouraged staff to offer plenty of drinks and staff said that they always left drinks in reach of people before leaving. The provider told us that people would be referred to their GP if there were concerns about their food and fluid intake or if they had lost weight.

People were involved in the regular monitoring of their health. Staff identified any concerns about people's health to the manager or team leaders, who then contacted their GP, community nurse, or other health professionals. Each person had a record of their medical history in their care plan, and details of their health needs. Records showed that staff worked closely with health professionals such as district nurses in regard to people's health needs. One relative said, "When Mum had a fall, even though I found her the carers stayed until we were sure she was comfortable".

All new staff completed an induction when they started in their role. Learning and development included face to face training courses, eLearning, and on the job coaching. The induction and refresher training included all essential training, such as moving and handling, fire safety, safeguarding, first aid, infection control and applying the Mental Capacity Act 2005. The provider was a trained trainer for moving and handling, but was currently checking when a further update of this training was needed. Staff confirmed they had undertaken training and we saw training certificates in staff files which confirmed this. This meant that staff understood how to maintain peoples' health and well-being and that people were supported by staff that had the skills and knowledge to meet their needs and ensure their safety.

Staff told us they were supported through individual supervision and appraisal. Records seen supported this. Spot checks of staff were carried out in people's homes. A spot check is an observation of staff performance carried out at random. These were discussed with people receiving support at the commencement of their care support. People thought it was good to see that the staff had regular checks, as this gave them confidence that staff were doing things properly. Spot checks were recorded and discussed, so that staff could learn from any mistakes, and receive encouragement and feedback about their work.

Good

Is the service caring?

Our findings

People said that staff were kind and caring. One person said, "The boss lady comes out sometimes, she has a very caring nature and chats away and we can have a laugh." Relatives said, "The manager comes out to give care sometimes, she is very kind and has a caring manner", and "I think they are delivering her personal care well, I am there sometimes and I hear them chatting and they will shut the door".

People valued their relationships with the staff team. They spoke highly of staff members. Staff listened to people and respected their wishes. One person told us, "I am usually out of bed when they arrive and they will give me a wash in the chair. They make sure the door is closed and have towels ready". Staff recognised the importance of self-esteem for people and supported them to dress in a way that reflected their personality. One member of staff said, "I go by what the person tells me they want". Staff provided caring and considerate support and respected people's privacy and dignity.

Staff were made aware of people's likes and dislikes to ensure the support they provided was informed by people's preferences. People told us they were involved in making decisions about their care and staff took account of their individual needs and preferences. For example, morning routines were written in the care plan records, and included the order in which the person liked their morning routine to be carried out. Regular reviews were carried out by the provider, and any changes were recorded as appropriate. This was to make sure that the staff were fully informed to enable them to meet the needs of the person. 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. Family members were involved as appropriate.

The provider had reliable procedures in place to keep people informed of any changes. The provider told us that people were informed if their regular member of staff was off sick, and which staff would replace them. People said that when they first started to use the service, they were given a time when their member of staff would arrive at their home. People confirmed to us that if staff were running late, they were informed. One relative said, "We live on a farm so there is always someone here and so times are not so important to us, but they do seem to come at roughly the same time every day".

The provider 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 office. 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.

Good

Is the service responsive?

Our findings

People described their staff as being 'supportive' and 'caring'. People received personalise care and support. They and the people that matter to them had been involved in identifying their needs, choices and preferences and how these should be met. People's care and support was set out in a written plan that described what staff need to do to make sure personalised care was provided. People's plans were reviewed on a regular basis or sooner if their needs changed and they were provided with support that met their needs and preferences.

Staff said they were informed about the people they supported as the care plans contained all the information they needed to provide individualised care to the person. The plans also included details of people's religious and cultural needs. 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 staff assisting new people, or for staff covering for others while on leave, when they knew the person less well than other people they supported, although they had been introduced.

The service was flexible and responsive to people's individual needs and preferences. Relatives told us that the service was flexible and had provided additional support to respond to urgent changes in need. Staff worked enthusiastically to support people to lead the life of their choosing and as a result their quality of life was enriched and optimised to the full.

The provider had a complaints and compliments procedure. The complaints procedure was clearly detailed for people within the information provided to people when they started with the service. The complaints policy available in the office showed expected timescales for complaints to be acknowledged and gave information about who to contact if a person was unhappy with the provider response. This included The Care Quality Commission (CQC) the Local Government Ombudsman (LGO). The provider told us there had been no formal complaints made. Relatives told us that they felt confident they would be listened to if the made a complaint. One relative said, "If I had a complain I would speak to the carer, in the past I have moaned if they send a carer that is not up to the job, they (carer) did not return so I assume that I was listened to". Another relative said, "I have a direct number to the manager so I would be able to complain and I would feel comfortable doing that". One person said, "I have never had to complain, but if I did I would call the office or contact CQC".

The provider confirmed that there had to date been no missed calls, and all people had received the relevant number of visits that had been agreed.

Jasmine Care South East provided care and support to people to enable them to maintain their independence and live in their own homes. At this time, the service did not provide care and support to people who were at the end stages of life.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives were mainly positive about the service they received. They all knew the manager by name, mainly because she delivered care at some stage to all of them. They all told us they were generally happy with the service they received.

The service had no registered manager. The provider was applying to be the registered manager, however the application form had been rejected by CQC due to the accuracy of the content, and at the time of the inspection the application had not been re-submitted.

The provider had failed to have a registered manager in place. This was a breach of section 22 of the Health and Social Care Act 2008.

There were previously no systems in place to be able to assess and monitor the quality of service provision and ensure any concerns were addressed promptly. The provider told us that they had contracted with an external consultancy company who were providing quality monitoring tools. For example, a monthly complaints/concerns log; a monthly accident/incident log; medication audit and staff training audit. We saw the forms and the provider said that she was about to start implementing regular audits. The provider told us that an external consultant would be visiting them on a monthly basis to support the provider with all the documentation they needed to implement and maintain. These checks were to be carried out to make sure that people were safe.

We recommend that the provider implements quality assurance auditing systems without delay, and have these documents monitored by the person from the external consultancy company on their monthly visits to the service.

Policies and procedures had also been provided by the consultancy company and were being put in place to make sure they reflected current research and guidance. Policies and procedures were available for staff. The provider's system ensured that the staff were aware of procedures to follow and of the standards of work expected of them to provide safe, effective, responsive care and support for people.

Staff said they liked working for the service. Our discussions with people, their relatives, the provider and staff showed us that there was an open culture that focused on people. Staff told us that the provider had an 'open door' policy which meant that staff could speak to them if they wished to do so. Staff told us there was good teamwork amongst staff.

Staff knew they were accountable to the provider and they said they would report any concerns to them. Staff meetings were held and minutes of staff meetings showed that staff were able to voice opinions. We asked staff if they felt comfortable in doing so and they replied that they could contribute to meeting agendas and 'be heard', acknowledged and supported. The provider had consistently taken account of people's and staff's views in order to take actions to improve the care people received. One member of staff said, "I have always been able to contact the provider for advice when needed".

People were invited to share their views about the service through one to one meetings, telephone calls from the provider and when the provider carried out personal care for people. The service worked in partnership with other agencies to enable people to receive 'joined-up' care.
The provider ensured that staff received consistent training, supervision and appraisal so that they understood their roles and could gain more skills. This led to the promotion of good working practices within the service.

The 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. 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 provider confirmed that no incidents had met the threshold for Duty of Candour. This demonstrated the provider understood their legal obligations.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. As this was the first inspection of the service, we discussed this requirement with the provider, to ensure that the rating would be displayed in the office and on the providers website.