Augusta Care Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

Augusta Care Limited based in Wisbech is a domiciliary care service registered to provide personal care to people in their own homes. People receiving care have a range of needs which includes learning disabilities. There were 13 younger adults being supported with the regulated activity of personal care at the time of our inspection.

This comprehensive inspection took place on 14 September 2016 and was announced. This was the first inspection of this service since it was registered with the Care Quality Commission on 12 January 2016.

There was a registered manager in place during this inspection. 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 Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and report on what we find. The registered manager had an understanding that people, who were being supported by the service and who lacked the mental capacity to make day-to-day decisions, should have an application to the Court of Protection made on their behalf. Staff were able to demonstrate a basic understanding of the MCA. Any decisions made on people's behalf by staff would be in their best interest and as least restrictive as possible.

People had care records in place which included information on how they wished to be supported to maintain their independence. However, people's personal development goals were not always listed as guidance for staff. Care records documented people's care and support requirements and any assessed risks.

People were assisted where required, to contact and access a range of external healthcare professionals. People were supported by staff where appropriate to prepare and help cook their own meals and make their own drinks.

People had their choices about how they would like to be supported respected by staff. People were assisted by staff in a caring manner. Staff promoted people's privacy and dignity.

Plans were in place to minimise people's identified risks and to prompt staff on how to assist them safely. These records and reviews of these records, documented that people and/or their appropriate relatives had been involved in and agreed their plan of care. However, some monitoring charts such as food and fluid intake risk assessments were not a detailed enough record for people deemed to be at risk. This meant that there was an increased risk that records could not detail whether a person at risk had drunk sufficient amounts of drink to prevent them becoming dehydrated or eaten sufficient amounts of food.

People were supported to maintain their links with the local community and promote their independence. People were helped to take part in recreational and work related activities.

Arrangements were in place to ensure that people's medicines were administered safely. Records regarding the administration of people's prescribed medicines were kept. People's care and support plans and risk assessments did not detail who was responsible for the ordering, collection and disposal of people's medicines. How people should store their medication safely had not been risk assessed. Risk assessments on whether this storage method was safe, would demonstrate whether there was a potential risk to people and/or the other people who shared their home.

There was a sufficient number of staff to provide people with safe support and care, agency staff were used to cover any shortfalls. Staff were trained to provide care and support which met people's individual needs. The standard of staff members' work performance was reviewed during supervisions and direct observations. This was to make sure that staff were competent and confident to provide the agreed care and support.

Staff understood their responsibility to report any suspicions of harm or poor care practice. There were pre-employment essential checks in place to ensure that all new staff were deemed safe and suitable to work with the people they supported.

There was a procedure in place to listen to people's complaints. The registered manager sought feedback about the quality of the service provided from people who used the service. Staff meetings took place and staff were encouraged to raise any suggestions or concerns that they may have had.

Quality monitoring processes to identify areas of improvement required within the service were in place. Improvements identified as required were either completed or were on-going.

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.

People's medicines were managed and administered as prescribed. A responsibility around the ordering, collection, disposal and safe storage of people's medication was not always documented.

Monitoring records were in place. Some of these records were not detailed enough for people deemed to be at risk.

People's care and support needs were met by a sufficient number of staff.

Staff were aware of their responsibility to report any concerns about poor care or suspicions of harm that people may experience.

Safety checks were in place to make sure that only staff that were deemed suitable to provide care for people were recruited.

Is the service effective?

Good

The service was effective.

People's health, nutritional and hydration needs were met.

Staff were aware of the key requirements of the Mental Capacity Act 2005 (MCA).

Staff were trained to support people to meet their needs. Supervisions and work performance observations were in place to monitor the quality of staffs work.

People were assisted with external healthcare appointments and referrals were made when needed.

Is the service caring?

Good

The service was caring.

Staff were kind and respectful in the way that they supported

and engaged people.

Staff respected people's right to privacy and dignity when delivering their personal care.

Staff encouraged people to make their own choices about what was important to them. Staff assisted people to maintain their independence.

Is the service responsive?

Good

The service was responsive.

There was a system in place to receive and manage people's concerns and complaints.

People were supported to maintain their links with the local community to promote their social inclusion.

People's care and support needs were planned and reviewed to make sure they met their current needs.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in place.

Audits were undertaken as part of the on-going quality monitoring process to identify and make improvement. Improvements had been made but were still on-going.

People who used the service were able to feedback on the quality of the service provided.

Augusta Care 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.

We undertook an announced inspection of Augusta Care Limited on 14 September 2016. We gave the service 48 hours' notice because we needed to be sure that the registered manager and staff would be available. The inspection was completed by one inspector.

We looked at information that we held about the service including information received and notifications. Notifications are information on important events that happen in the service that the provider is required to notify us about by law.

During the inspection we visited the service's office and three of the homes where people lived. We spoke with five people who used the service. We also observed how the staff interacted with people who had limited or no communication skills. This was to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, the team manager, and two care workers. We requested feedback about the quality of the service provided from a representative of the Cambridgeshire and Peterborough Clinical Commissioning Group; Healthwatch Cambridgeshire; and the contracts monitoring teams from Cambridgeshire and Peterborough. We received feedback about the service provided from a representative of the Norfolk Council quality team.

We looked at four people's care records, two staff recruitment files and the systems for monitoring staff training and development. We looked at other documentation such as quality monitoring, minutes of meetings and medicine administration records.

Requires Improvement

Is the service safe?

Our findings

On review of people's care records we saw that people's care and support needs had been assessed and documented. People's risks had been identified and evaluated to reduce the risk of harm and where appropriate people were supported by the 'best interest' decision making process. This was to make sure that people were supported in a lawful manner.

People had individual risk assessments and care and support plans in place. These included, but were not limited to; risks to the person within the community and home environment; healthy eating; financial budgeting; attending health appointments; neglecting personal care; behaviours that challenge and medicine administration. We noted that these records gave individual prompts to staff to help assist people to live as independent and safe a life as possible. This included how staff should deescalate a person's escalating anxieties. Guidance included, "leave me to calm down and return in 15 minutes." It also included how food should be presented to a person and how they were to be monitored whilst eating and drinking. This was to reduce the risk of choking. These guidelines for staff were in accordance with speech and language therapist guidelines. However, one out of the four care records we looked at did not have a plan of care and support and/or a risk assessment around a person's specific health condition. We spoke with the registered manager about this during the inspection who confirmed that this deficiency would be rectified as a matter of priority. A social care professional told us that they had some concerns that staff did not always follow external health professional's guidelines about how to manage people's deemed risks or health conditions. This indicated to us that there could be an increased risk of people receiving inappropriate or unsafe care and assistance.

Records were also in place for staff to monitor people's risk, for example when a person was at risk of weight decrease/ increase or at risk of not drinking enough fluids. We saw that food and fluid charts were in place for those deemed to be at risk; however, we noted that these records were not always detailed enough. Staff had recorded what had been eaten and drunk on a daily basis, but sometimes the amount was documented, as 'all' instead of the specific amount. This meant that there was an increased risk that records could not detail whether a person at risk had drunk sufficient amounts of drink to prevent them becoming dehydrated or eaten sufficient amounts of food. The registered manager told us that they would amend these records to allow staff to enter more detail when monitoring a person they supported.

Care records documented whether the person or staff were responsible for administering people's medication. Accurate records documenting this support from staff were kept. People we spoke with were supported with their medication by staff members. One person said, "Staff watch me take my medicines." Staff who administered medication told us that they received training and were subjected to observed checks by management. This was to monitor their competencies. Records looked at confirmed this.

We noted that there were clear instructions for staff in respect of how and when medicines were to be administered safely, including those to be given 'as required.' One staff member confirmed to us that they, "Were responsible for the ordering, collecting and disposing of meds [medicines]." However, people's care records did not formally document this information. These records also did not document any assessments

carried out by the provider on how each person stored their medication safely within their own home. This included information on whether this storage method was a potential risk to them and/or the other people who shared the home. We spoke to the registered manager about this during the inspection. They said that they would look at these records and update them to include an assessment of this potential risk.

People who were able to communicate with us, when asked if they felt safe using the service answered, "Yes." This was because of the quality of the care and support that was provided to them.

Staff told us that they had completed safeguarding training and records we looked at confirmed this. Staff demonstrated to us their knowledge on how to identify the different types of harm and report any suspicions of this or poor care practice. Staff told us what action they would take in protecting people and reporting such occurrences. One member of staff said, "I would inform my line manager." Staff were also aware of external agencies they could contact. These included the local authority, the police or the Care Quality Commission to report suspicions of poor care practice. This showed us that there were procedures in place to reduce people's risk of harm.

Staff demonstrated to us their knowledge and understanding of the whistle-blowing procedure. They knew the provider's process to follow if they had any concerns to raise and said that they were confident to do so. One staff member said, "If you don't report concerns of poor care you are just as guilty. If you are not prepared to whistle-blow then you should not [be working] in the care industry." This meant that staff understood their roles and responsibility in protecting the people they assisted.

Staff said and records confirmed to us that essential pre-employment safety checks were carried out prior to them starting work and providing care. One staff member said, "I had to have my DBS [criminal records check] and references in place again when I re-joined [the organisation]." Safety checks included references from previous employments. A criminal record check that had been undertaken with the disclosure and barring service and staff's proof of identity was in place. Any gaps in a staff members' previous employment history and their reason for leaving the role had been documented. These checks were in place to make sure that staff were deemed to be of a good character and that they were suitable to work with people who used the service.

We found that people had personal emergency evacuation plans in place as guidance for staff. This showed that there was information for staff in place to assist people to be evacuated safely in the event of a foreseeable emergency such as a fire.

We observed that there were enough staff to safely provide the required care and support which included any one to one assistance people needed. Records showed that there was enough staff available to work, to meet the number of care hours contracted / commissioned with assistance from temporary staff from an agency. One staff member said, "I feel that staffing is slightly short [on numbers], but no one [staff] is pressured to cover a shift…there is a massive recruitment drive currently. They [management] are trying; you cannot magic staff out of thin air."

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.

We checked whether the service was working within the principles of the MCA. We spoke with the registered manager about the MCA and Court of Protection. We found that they were aware that they needed to safeguard the rights of people who were assessed as being unable to make their own decisions and choices. The registered manager told us that during this inspection some people being supported by the service lacked the mental capacity to make day-to-day decisions or bigger decisions. This meant that there had been applications made to the Court of Protection.

Staff told us and records showed that staff had training on the MCA. One staff member said, "Just because you think that a person can't make a decision in one area [of their life] does not mean that they don't have capacity in all areas. A person may have capacity some times, but not other times. You then make a best interest decision." Another staff member told us that for people who lacked capacity, "Daily life decisions are made in their best interest. Visual prompts can be used to help [people] with their decision making." Staff were able to demonstrate to us a basic understanding of the MCA and how people could be supported in their best interest and with the least restrictions. This understanding from staff meant that any decisions made on people's behalf by staff would be in their 'best interest' and as least restrictive as possible.

People told us that where needed, they were supported by staff with the preparation of meals and drinks. This was confirmed during our observations. During our visit to people's shared houses we saw that fresh fruit and drinks were available to people. One person told us that they, "Get a choice of food," And that they can, "Get their own water [to drink]." We observed that for those people who required assistance with their meals, they were supported and encouraged to eat by staff. This was at a pace the person preferred. On speaking to staff they were able to describe to us how they assisted people with special dietary requirements such a 'soft' food diet. They explained that these, "Soft," or "Fork mashable [softened consistency]," diets would be in place for people's identified at being at risk of poor swallowing.

Staff had an induction period which included mandatory training and the shadowing a more experienced member of staff and attending supervisions. We saw evidence that the provider had adopted the Care Certificate induction training programme. This is a nationally recognised training scheme. All new staff had to complete an induction period until they were deemed competent and confident by the registered manager to deliver effective care and support.

Staff told us about the training they had completed to make sure that they had the skills and knowledge to provide the individual care and support people needed. This was confirmed by the record of staff training undertaken to date we looked at. One staff member said, "I feel like I am given the training I need." Training

included, but was not limited to; epilepsy; learning disabilities and autism; moving and handling; safeguarding adults; fluids and nutrition; food hygiene; first aid; and diabetes. Staff were also trained in the MCA and DoLS; infection prevention and control and medicines administration. Staff talked us through the development of their skills and knowledge as they were being supported to complete national vocational qualifications in health and social care. This indicated to us that staff were trained to assist the people they were supporting.

Staff members told us they enjoyed their work and felt supported. Staff said they attended staff meetings. A staff member told us that staff meetings were, "More regular [under the new registered manager]." Another staff member said that reviews of their work were a, "Two way process." Staff said that they received formal supervision, work performance observations to review their skills and develop their knowledge. Appraisals had not yet been completed by the registered manager as the service had not been registered for 12 months yet. This showed us that staff were supported to develop and maintain their skills.

We saw documented evidence and people told us that staff supported them to attend external health care appointments. One person told us that they, "Saw [the] doctor yesterday." Care records looked at showed that staff referred and supported people to contact or visit external healthcare professionals such as, doctors, occupational therapists, and speech and language therapists if needed. This showed us that staff supported people where required.

Good

Is the service caring?

Our findings

People had positive comments about the care provided by members of staff. This was confirmed by our observations. One person said that they were, "Happy," and another person told us that, "Staff are kind to me." A third person also confirmed to us that staff were, "Kind."

Staff told us how they respected people's choice about how they wished to be assisted. People who were able to communicate this told us that staff gave them a choice. This was noted during our observations when we saw staff promoting people's wishes by giving them choice over what they wanted to eat and drink.

People were also enabled to sit where they would like. They were able to choose if they wanted to be in a communal room within the shared houses or their own room. We saw that people were able to make choices about how they spent their time, which included, with the support of staff, going out and about to promote their independence. People's care records showed that people wanted to maintain their level of independence and continue living in their own home with support from staff. These wishes were then taken into consideration when planning all aspects of their care. Records we looked at documented that people, their appropriate relatives, or their legal representatives were involved in the agreement of people's plans care. Where people did not have this support we saw documented that staff were to assist people in their 'best interest.'

Arrangements were in place to use consistent staff members to build up the trust and knowledge of the person they were assisting. Staff promoted people's privacy and dignity when supporting them with personal care, by providing this help behind closed doors. We saw that staff assisted people they cared for in a kind and respectful manner. One person told us about the positive relationship they had built up with staff. They said, "I tease them [staff] and they tease me – we joke." Another person talked us through the emotional support given to them when needed, which they had appreciated. This demonstrated to us that people were valued and respected.

One person showed us how staff supported them with household chores, and how they had done their own laundry. Another person told us, "Staff helped me with tidying my room and I did the laundry today." This meant that people were assisted by staff to maintain their life skills. However, not all care records we looked at documented the support needed from staff to continue to develop people's future personal goals and life skills. This was confirmed by a social care professional we spoke with. The development in life skills from staff would enable people where possible to maintain and increase their independence.

Advocacy was available for people if they needed to be supported with this type of service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw documented evidence that people had advocates in place to support them with their financial affairs.

Good

Is the service responsive?

Our findings

People's care and support needs were planned to make sure that their individual needs were met. Staff told us that they read people's care and support plans before delivering care. Staff told us that if they felt that the support and care plans needed updating they would contact the provider and this would be actioned.

Care records we looked at detailed how many care workers should support a person in response to their assessed needs. For example, when staff were moving and repositioning a person safely. Communication passports within people's care records documented 'what you need to know about me.' These gave prompts to staff on the best way to communicate with the person they were assisting. Guidance included, for example, "Make eye contact," for a person who communicated using their eyes. For another person the guidance stated, "Information to be given using simple clear and small chunks, using visual aids." This helped staff members respond to the wishes and choices of the person they were assisting.

There were details in place regarding the person's family contacts, and any health care professionals such as doctors who were involved in the persons care and treatment. An individualised care and support plan was then developed by the provider in conjunction with the person, and/or their family. This was when the person was new to the service to provide information to staff on the care and support the person required.

Support that people received included, but were not limited to; assistance with personal care and with the preparation of meals and drinks, and attending health care appointments. They were also assisted by staff with the management of their day to day finances, trips out into the community and their prescribed medication. We noted that staff supported some people to access the local community to promote social inclusion, using public transport or the person's own mobility vehicle. One person told us, "I went to the zoo this week." They also told us that they were saving up for their holiday. Another person worked as a volunteer for a local charity and a third person had been on a recent visit to the sea-side. We observed day-to-day activities that people enjoyed and this included playing darts and completing jigsaw puzzles. One person told us, "I like puzzles."

Information on how to raise a concern or complaint was documented in the service user handbook. This is a booklet given out to all new people to the service. We noted that the handbook was not in an easy read format. This format would enable more people who used the service to read and understand the content. We spoke the registered manager about this and they told us that the provider was looking into correcting this deficiency.

During this inspection we saw that there were no complaints records held. The registered manager told us that this was because the service, since it registered in January 2016, had not received any complaints. Staff said that they knew the process for reporting concerns raised with them by the people they supported. One staff member told us, "I would ask the person's permission to tell management so it would get resolved." We noted that there was a formal process in place to receive and resolve any complaints received.

Good

Is the service well-led?

Our findings

There was a registered manager in place. They were currently being supported by care and office staff.

Staff told us that an 'open' culture existed and they were free to make suggestions, raise concerns, drive improvement and that the registered manager was supportive to them. Staff told us that the registered manager and management were approachable and that staff could speak to them if they wished to do so. One staff member told us, "I feel listened to." Another staff member said, "The team of staff support each other. Staff morale is quite good." We saw that the provider had a certificate of accreditation in, 'investors in people' and that they had been recognised as a 'skills for care provider.' Both of which are national organisations. This showed us that the provider sought recognition from external organisations.

Staff meetings took place and staff told us that they were able to raise any concerns or suggestions that they may have. Records showed us that these meetings were also used by the registered manager to update staff. Updates included any changes to the service, policies and in the people they supported. One staff member said that at these meetings, "Staff will speak out [if they have any suggestions / concerns]."

All staff spoken with confirmed that their role and the values of the service were to give people the best care they could. One staff member said the provider's core value was, "Supporting people." Another staff member told us that the provider's values were to, "Do what's best for the service user…give them the best life possible, give choices."

Records showed that people were given opportunities to feedback on the quality of the service provided through meetings. We saw that as a result of these meetings improvements had been made including the purchase of some new saucepans for one of the shared houses. As the service had only been registered since January 2016, the registered manager had not yet sent out questionnaires to ask people and their relatives to formally feedback on the quality of the service. They told us that this was to be actioned later on in the year.

A system to regularly audit the quality of the service provided was in place. Any improvements required were recorded in an action plan to be worked on. Areas that formed part of the quality monitoring included, support plans and risk assessments; MCA documentation and people's capacity to consent to care. Environmental risks; external health care guidelines and people's medication support and daily dairy entries by staff were also reviewed as part of these checks. Records showed any improvement actions taken as a result of these audits, including a prompt for staff to ensure that all 'outstanding' documents held within people's care records were However, as found during this inspection some actions required to improve documentation within the service had not yet been completed and were on-going.

Accidents and incidents were recorded. These records included a summary of the incident and the outcome. We noted that there were actions recorded against these documents to reduce the risk of reoccurrence.

The registered manager notified the CQC of incidents that occurred within the service that they were legally

obliged to inform us about. This was done in a timely manner. This showed us that the registered manager had an understanding of their role and responsibilities as a registered person.