Assured Care (Stockport) Ltd

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Inspection report

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Date of inspection visit:
12 October 2016

Date of publication:
30 November 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

Assured Care (Stockport) Limited provides twenty four hour domiciliary care and support to adults in their own home. The service's office is located in Stockport near Manchester.

This was an announced inspection on the 12 October 2016. Two days prior to the inspection, we contacted the provider and told them of our plans to carry out a comprehensive inspection of the service. This was because we needed to be sure that someone would at the office.

The service had a registered manager in place at the time of our 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.

Policies and procedures were in place to safeguard people from abuse and staff had received training in safeguarding adults. Staff were recruited robustly to ensure they were suitable to work with vulnerable adults.

Policies, procedures and staff training should mean the administration of medicines was safe.

Staff had access to infection prevention and control training, policies and procedures to help prevent the spread of infection.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards.

People were supported to take a nutritious diet and sufficient fluids to remain healthy.

Staff induction and training was ongoing to support them to look after people who used the service. Supervision had recommenced after a gap. Staff told us they felt able to contact managers if they needed to and felt supported. We made a recommendation that the registered manager look at best practice guidance around the frequency and content of formal supervision sessions for staff.

We saw the office was sufficiently well equipped to provide a good service.

We saw from looking at plans of care and speaking with people who used the service that people were asked to give their consent to care and treatment.

People who used the service told us staff were kind and caring. From our observations we saw that staff had a good rapport with people and knew them well.

We saw records were stored confidentially and plans of care were individualised to each person, were kept up to date and audited by managers.

People told us they felt staff would listen to them if they had any concerns and were given information about how to complain if they wanted to.

There were systems in place to monitor the quality of service provision. Policies and procedures gave staff information about best practice for many topics such as medicines administration, safeguarding and infection control.

People and professionals were given documentation which informed them of what the service did or did not provide to help assist them to make a choice to use the service.

People were asked their views in questionnaires to help the service maintain or improve the quality of the service. Staff were also able to air their views at meetings.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were administered safely by staff who had been trained to do so.

There were policies and procedures for safeguarding adults and staff were trained to respond to protect people from abuse.

Staff were recruited safely using robust procedures.

Is the service effective?

Good

The service was effective.

Staff received the induction, training and support they needed to carry out their roles effectively.

People who used the service were supported to take a healthy diet. Staff had received training in nutrition and gave support and advice to people who used the service.

People's rights and choices were respected. Staff had been trained in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

We observed the good rapport between staff and people who used the service who came to see us on the day of the inspection.

Personal records were stored securely to keep them confidential.

People who used the service told us staff were caring and kind.

Is the service responsive?

Good

The service was responsive.

People who used the service said they felt able to raise any concerns with their support workers or the registered manager. Plans of care contained sufficient details of a person's health and social care needs for staff to provide suitable care.

People were assisted to attend activities if this was a part of their care package such as shopping or life skills.

Is the service well-led?

Good

The service was well led.

There were sufficient audits to ensure the quality of service provision was maintained.

Staff told us managers were supportive and they all supported each other to work as a team.

There were robust systems in place to assess, monitor and review the quality of the service.

Assured Care (Stockport) Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 12 October 2016 and was announced.

The inspection team consisted of one adult social care inspector.

We did not ask for a Provider Information Return (PIR) because the provider would not have had sufficient time to respond to our request. Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform what areas we would focus on as part of our inspection.

We spoke with the registered manager, the nominated person, three members of staff and three people who used the service who we visited in their homes with permission.

We looked at the care records for four people who used the service and 18 medicines records. We also looked at four staff personnel files and a range of records relating to how the service was managed, these included training records, quality assurance systems and policies and procedures.

Good

Is the service safe?

Our findings

People who used the service told us, "I trust all the staff I get. I always remind them to lock up and they do it. They wear a uniform so I know it is them. I feel very safe letting them in my house", "I have felt safe with every member of staff who has come here" and "I feel safe with the staff who come here and trust them."

We saw from the training matrix and staff files that staff had received safeguarding training. Staff had policies and procedures to report safeguarding issues and also used the local social services department's adult abuse procedures to follow a local initiative. This procedure provided staff with the contact details they could report any suspected abuse to. The policies and procedures we looked at told staff about the types of abuse, how to report abuse and what to do to keep people safe. The service also provided a whistle blowing policy. This policy made a commitment by the organisation to protect staff who reported safeguarding incidents in good faith. There had not been any safeguarding incidents at the service. Staff told us they would use the whistle blowing policy to report poor or abusive practice.

We looked at three staff records and found recruitment was robust. The staff files contained a criminal records check called a Disclosure and Barring Service check (DBS). This check also examined if prospective staff had at any time been regarded as unsuitable to work with vulnerable adults. The files also contained two written references, an application form (where any gaps in employment could be investigated) and proof of address and identity. The checks should ensure staff were safe to work with vulnerable people.

People who used the service told us, "I take my own pills. Staff do not need to do that" and "I take my own medicines although staff may ask me if I have had them." Of the three people we visited two people self-administered their medicines and one family member was responsible for medicines administration.

People who use domiciliary care services, if able, tend to self-administer their medicines. However, if a part of their care package was for staff to prompt or administer medicines for people this was recorded in their plans of care. We saw there was a risk assessment in the plans of care to determine if a person could safely self-administer medicines.

We looked at the policies and procedures for the administration of medicines. The policies and procedures informed staff of all aspects of medicines management which included ordering, administration, recording, storage and disposal. All staff who supported people to take their medicines had been trained to do so. We looked at 18 medicines records (MAR) and found they had been completed accurately. There were no unexplained gaps or omissions. The MAR sheets and medicines were checked regularly by care staff and managers. This helped prevent or spot any medicines errors. Management also conducted spot checks on staff to check on care practices including the safe administration of medicines.

There were separate recording sheets for 'as required medicines'. This informed staff what the medicines were for, how often they should be given and the maximum number that could be given in a twenty four hour period to minimise the possibility of overdose. This system helped safeguard the health and welfare of people who used the service.

We saw from the three plans of care that staff used a body map to direct staff on where to apply any creams or ointments, which was colour coded when there was more than cream to apply to avoid any confusion.

We saw that staff had online access to the British National Formulary which meant they were able to use the formulary to check up on any possible side effects or what a medicine was for.

There were infection prevention and control policies and procedures staff could use to follow good practice. The training matrix showed us most staff had undertaken training in infection control topics. Staff we spoke with confirmed they had undertaken infection control training. Staff had access to personal protective equipment (PPE) and we observed staff used gloves and aprons when supporting people who used the service. People lived in their own homes and were responsible, unless it was a part of their care package, to keep their homes clean and tidy. The registered manager said they would advise people and possibly seek further professional advice if a person had poor hygiene practices and their health was at risk.

We saw that there were systems in the office, for example checking fire equipment was working, fire drills, portable appliance testing and the maintenance of extinguishers to keep staff safe whilst working. The service also had a business continuity and contingency plan which gave staff advice on what to do should there be a significant event such as a power shortage or gas failure. In the event of disruption to the service, for example bad weather, the service had assessed people's dependency which meant they would be able to divert staff to the people most at risk. The telephone numbers of staff and other organisations such as social workers and age concern were contained within the document to enable staff to quickly notify people in an emergency situation.

We saw in the plans of care that people had risk assessments for moving and handling, falls and tissue viability (pressure sores). Each person's home was risk assessed for any hazards to staff. This looked at risks such as tripping hazards, poor lighting and access to the property and helped protect staff from possible accidents.

Good

Is the service effective?

Our findings

People who used the service told us, "They are reliable although they sometimes get stuck in traffic which is unavoidable", "They are reliable and come on time and stay for as long as they are allowed to" and "They are reliable and traffic apart they stick to the times they are supposed to come."

A staff member said, "There could be more staff but we meet people's needs. There are enough staff for that." There was a system to check when staff arrived and left the service, which was regularly checked by the service and local authority. On the day of the inspection an administrative member of staff was contacting care staff to remind them to ensure they entered their calls onto the system. The service faced financial penalties from the local authority if the calls were not completed or inaccurate. The service therefore had to ensure staff arrived and stayed for the allotted time and also ensured there were enough staff to meet people's needs.

People lived in their own homes and were mainly responsible for choosing their own diet. Some people required staff assistance at mealtimes to prepare food. We saw from looking at the staff training matrix that staff had been trained in safe food handling. The registered manager showed us a course for nutrition that staff were being enrolled on so they could better advise people who used the service on taking a balanced diet.

The registered manager said, "Normally people who live in their own homes are responsible for their own diet, they are encouraged to eat what they like and that it is nutritious. People can have their choice if they have mental capacity but we would give advice and contact social workers or families if we needed to for advice if we thought someone was not taking sufficient food and fluids. We record what a person has eaten each day." This meant the service were aware of their responsibilities to ensure people ate healthily.

We saw that staff had recorded where food had needed to be discarded as out of date or unfit to eat after discussion with the person who used the service. This was recorded so that family members and possibly a forgetful person would know why the food was missing and had not been eaten or stolen.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). The 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People who live in their own homes are not usually subject to a DoLS. The registered manager and some staff had undertaken training in the MCA and DoLS and would be aware to contact the local authority safeguarding team if they thought someone was being abused.

A staff member who had only worked at the service for a few weeks said, "I had an induction when I came here. We had to do some training first and then after that reading the policies and procedures. We went through the medicines procedures and how to write daily records. I was also taught moving and handling, how to wear and safely use personal protective equipment and how to dispose of soiled items safely. I also had to complete safeguarding training. I was introduced to the people we care for. I was shadowed until I could work on my own. I am going to complete the care certificate next. I was given enough support and confidence to do the job. They are at the end of the phone and you can ring them if you need to."

One new staff member was going through part of the induction process on the day of the inspection and took away a copy of the care certificate documentation ready for it to be completed when they commenced work. We looked at the process. Staff were given the option of completing the work in their own time at home or attend at the office whichever suited them best. The induction consisted of the training necessary to start on their care career and sufficient support to meet the needs of people who used the service. We also saw in staff files documentation which showed one staff member was part way through the care certificate and one staff member had completed it. The care certificate is considered best practice for people new to the care industry.

A person who used the service said, "The staff seem to be well trained to me." Staff told us, "I feel fine with the training", "I am happy with the training we do and at this time do not think I need anything else. We can contact the office if we need to for any extra training like catheter care" and "I think we have enough training to do the job. If we are unsure of something we are advised about what we need to do."

We looked at the training matrix, three staff files and talked to two staff about their training. This showed that staff had received the essential training needed to provide care and support to the person they were working with. We saw training staff had received included; health & safety, first aid, food hygiene, fire safety, safeguarding, the MCA and DoLS, medicines administration, confidentiality , moving and handling, infection control and continence management. Staff records we saw contained certificates for the training staff had completed. Staff were then encouraged to complete further training in health and social care such as a diploma.

Staff told us, "I think we are supported by management and you can contact them early in the morning or evening. Any questions, queries or worries will be attended to", You can get hold of managers whenever you want. They support us with any issues and although I don't need the extra support it is there if I need it" and "We have supervision but I think being available to talk to the managers is more important if you have anything you need to discuss and they are always available." We saw that staff had recently been given the opportunity to discuss their careers and needs at a supervision session. We saw there were some supervision records in staff files. There had been a break in giving staff the opportunity to formally sit down and discuss working at the service although staff did not feel it had an impact on them. The registered manager said the person who undertook supervisions had left the service and whilst they still undertook spot checks for staff competence they were aware of and had responded to the needs of staff by arranging a supervision matrix, which we looked at and showed they were now completing them. Staff were able to air their views at staff meetings. Staff also had an annual appraisal to help support them in their roles. We recommended that the registered manager look at best practice guidance around the frequency and content of formal supervision sessions for staff.

The office was located on the outskirts of Stockport. There were rooms for staff training or to meet in private. There was sufficient equipment to run a domiciliary service such as telephones, computers with email access and printers. There were facilities for staff to make refreshments.

We saw that two plans of care had been signed by people who used the service and one by a family member. However this person had the mental capacity to sign but preferred his family member to be involved. This meant people agreed to their care and treatment.

Good

Is the service caring?

Our findings

People who used the service told us, "Some staff are good and some are not so good but I am satisfied with the staff I have now. I am happy with the care they give me. They look after me very well", "The staff are very good, marvellous in fact. They make life really happy for me" and "The staff are kind and caring." People who we spoke with thought staff were caring and met their needs.

Staff members said, "You become like a family member although it upsets me that some people only see care staff in a day. People can be very lonely. I love the job really" and "I like working here. There is a good team and I get satisfaction when somebodies health improves or they become more independent." Staff we spoke with were happy working at the agency.

We visited three people in their homes with their permission. A member of staff accompanied us so that people had someone they knew coming to their home and we saw two staff working with a person during the visits. The person who accompanied us was not a care staff member but people had a good rapport with them and obviously knew the staff member well. There was a good atmosphere and appropriate light hearted conversation. People who used the service obviously enjoyed the staff members company and were interested in being involved in conversation around health and family matters. The two staff members who were completing a person's movement into the lounge were professional and friendly.

Staff were trained in confidentiality topics, had confidentiality guidance in their handbooks and we saw that records were stored securely in the office to keep them private. The office was secured with a keypad lock which prevented anyone entering the office unexpectedly.

We saw that plans of care were individual to each person and had been developed with them. This showed that people's likes, dislikes and choices were taken into account and should mean that people found their care was what they needed.

Good

Is the service responsive?

Our findings

People who used the service told us, "I am confident they would listen to us if we had any concerns. They better had", "I think the service would listen to me if I had any concerns and I know who I can contact" and "I could talk to any of the staff if I had any concerns. I also have the numbers of the office to call if I needed to."

Each person was issued with a document called a service user guide. Within this document there was a complaints procedure. We saw the complaints procedure told people how to complain, who they could complain to and the time it would take for the service to respond. There was a system for auditing complaints which should mean people's concerns were responded to and action taken to resolve any issues. The people we spoke with told us they felt confident the service would listen to them and any concerns they had would be investigated.

Domiciliary care services do not normally provide activities. The registered manager told us they supported people to go shopping, assisted with life skills such as cooking and took one person to college and other places of interest.

Prior to using the service people were assessed by a member of staff from the agency. Social services who made the referral also supplied information to aid the assessment. We saw from plans of care that assessments were thorough and took people's views into account. The assessment was used to help develop the plans of care.

People who used the service said, "We get the care we need we do not need to look at the care plan" and "The staff know what they are doing for me and always ask me if they are not sure."

We looked at three people's plan of care in the office and one with permission in a person's home. Dependent upon the care needed people could have up to four visits a day. The care plans also told us how long a staff member had to spend at each visit. One plan we looked at showed staff supported someone four times a day. On the morning visit support was around getting the person up and given breakfast. The plans clearly told staff what tasks must be completed. We saw that this also gave staff information such as any specific personal care needs, medicines administration or creams that needed to be applied. We saw staff were instructed to offer choice with how a person was kept clean, what clothes they wore and what they wanted to eat. Staff were instructed to ask people at the end of their support session to ask people who used the service if they had everything they needed until the next session and to complete the daily logs. This was repeated for the lunch, tea and evening visits, informing staff of the care they were to give and which we saw was appropriate for the time of the visits.

Plans of care contained some background history including why the person needed to use the service, what they liked to do, for example one person liked to use public transport to go out for pub lunches, reading, watching television and socialising. We also saw that a person's level of independence was also recorded so staff would know what a person could or could not do. This included the use of any equipment a person required such as a walking frame. The plans gave staff all the personal information they may need, for

example, the next of kin, GP, and any religious or cultural needs. The plans were regularly reviewed. Daily records we looked at showed staff recorded what they had done at each visit and if a person had taken their diet.

Staff were issued with a handbook staff could refer to, which gave them details of good practice guidelines to help them respond to people's needs in a professional way. The document told staff what they could or could not do, for example not syringing a person's ears, support whilst working, training and supervision and good conduct advice.

Good

Is the service well-led?

Our findings

The service had a registered manager in place at the time of our 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.

People who used the service said, "We have been able to contact the office if we have needed to. All the numbers are in the file. They are all approachable. We are very satisfied with Assured Care. We should be we have used them for years", "This is a very good service and I am pleased I have it. I really enjoy the company of the care staff. Our new carer is very good, well they are all good. We have the numbers to call if we need them and occasionally we need to cancel a visit" and "All in all I am very happy with the care and staff I get. You can talk to any of the staff from managers to carers."

Staff said, "I feel supported by the registered manager and provider. They are approachable.
I think we work as a team and they supervise us. If you have any concerns they will help. If I suggest something they will listen and if it is a valid idea they will take it up. There is a good staff team" and "I think we are well supported. The managers are approachable and available for advice. A manager also told us, "We are in regular contact with staff. We pass on information to staff about any changes or if they had concerns they would ring the office or our mobiles."

There was a management structure staff could understand and all the people we spoke with thought the managers were available when they needed them. We observed that staff knew the people they looked after well and gave them the support they needed.

Before the inspection we saw the registered manager had notified us of any incidents. We saw there were systems in place to audit incidents, complaints and accidents to help minimise them.

There were policies and procedures for staff to follow good practice. We looked at several policies which included safeguarding, infection control, use of social media, moving and handling, DoLS, privacy and dignity, confidentiality, complaints, medicines administration and nutrition. The policies were reviewed regularly to ensure staff were supplied with up to date information.

We found there was a robust system of quality assurance. Management audited the time of visits and duration staff spent with people who used the service, plans of care, medicines administration and any concerns or incidents. The service also conducted spot checks to look at people's care and to get feedback from people who used the service.

We saw that regular staff meetings were held to gain the views of staff. Topics included out of hours calls to senior staff, the procedures to follow if a service user did not answer the door, rotas, the use of PPE, call logging, personal care and infection control. Staff were able to bring up topics they wished to be discussed

at the meetings.

The service issued all people who used the service with a document called a service user guide. This gave people who used the service sufficient information about the services provided to know what support they could or could not expect and enabled them to make an informed choice to use the service. The document also gave people information such as the qualifications of staff and useful numbers to call if a person needed to.

There was also a statement of purpose which informed professionals of what the service provided, the management structure, the names of key staff, induction and training, hours of contact, the aims and objectives of the service, people's rights to privacy, the promotion of independence and other useful information. This helped professionals understand how the service was run and operated.

We saw the results of surveys undertaken by the service. We looked at 27 surveys and saw the results were mostly positive. Comments included, "I have always been cared for by lovely staff", "Staff are all caring and helpful" and "No complaints, the service is good."