

Ablewell Limited

Ablewell Care

Inspection report

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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?

Requires Improvement ●

Summary of findings

Overall summary

This announced inspection took place on 9 and 10 August 2018 and was announced. It was the first rated inspection since the location was registered with CQC on 30 April 2015.

Ablewell Care is a domiciliary care service providing personal care to people living in their own houses who misuse drugs or alcohol, who had dementia, learning difficulties or autism spectrum disorders. At the time of our inspection they were providing a service for 91 people and they had 42 care staff.

A condition of registration with CQC is for there to be a registered manager in post. There was no registered manager in post at the time of this inspection. The Nominated Individual was mentoring a manager to develop into becoming registered manager in due course.

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.

We found although there were quality assurance systems in place at the time of our inspection, further improvements were required to ensure the governance was robust. For instance, not all statutory notifications had been reported to us. The submission of a statutory notification is a legal requirement when specific incidents or events had taken place in the service.

We also found safeguarding concerns were not being tracked with an outcome or analysis for trends or themes.

There was a complaints process and procedure in place however, further improvements were needed to ensure it was clearer for people what constituted a complaint. The provider had identified this from their customer feedback survey.

A recruitment audit had been completed by the provider and seven staff recruitment files only had one reference from a previous employer. The provider had therefore, identified this and were taking action to improve this.

The governance arrangements were clear with numerous quality checks in place such as monthly auditing of daily records and medication administration sheets {MARS}, recruitment practices, analysis of incidents, customer feedback and complaints.

Safeguarding concerns were being logged and reported to the Safeguarding Authority appropriately. Staff were aware of their responsibilities and were raising concern when they suspected abuse. The provider had a whistleblowing policy in place for staff to follow.

There were enough staff to deliver care for people when they needed it. People told us if the carer was running late they would phone them to inform them. Any missed visits were investigated and the root cause identified.

Medicines were being managed safely with medication administration sheets being completed. Medication errors were being recorded and analysed.

Staff were caring and were encouraging people to have as much independence as possible. People we spoke with told us they were treated with respect and dignity.

People were being asked for their consent and the service was working within the Mental Capacity Act 2005 framework.

People were receiving person centred care and were being involved in their plan of care. Likes, dislikes and preferences were being recorded.

People's care needs were being assessed and the service were in the process of implementing the Herbert protocol which is good practice in identifying who may be at risk of becoming a missing person.

Healthcare professionals were being involved in people's care and staff communicated with them when needed.

The provider had implemented policies in relation to Equality and Diversity and were promoting people's rights.

The service was seeking people's views in the form of surveys and monthly reviews. A newsletter was sent out to people to inform them of anything new or changes in the service.

The provider was seeking to encourage people to work within the health and social care sector and was working on this with other outside agencies. The culture of the service was to continuously improve for the benefit of the people needing care and support.

The service offered staff a range of training which was delivered online and in the classroom. All staff were working towards the Care Certificate or had completed it. Staff were actively encouraged to complete other qualifications in care.

Supervision and appraisals were being undertaken. Staff meetings were being held and there was an "open door policy" by the managers.

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.

There were enough staff to deliver a safe level of care.

Systems were in place to ensure medicines were being managed safely.

Staff were aware of their responsibilities to safeguard people.

Is the service effective?

Good ●

The service was effective.

Staff were receiving training and were knowledgeable about the delivery of care.

Staff were receiving supervisions and appraisals.

People were supported to make their own choices in line with the MCA 2005 legislation.

Is the service caring?

Good ●

The service was caring.

Staff we spoke with had positive and caring attitudes towards people receiving a service.

People told us they were being encouraged to be independent.

The service were upholding people's dignity and had a good level of knowledge of Equality, Diversity and Human Rights {EDHR}.

Is the service responsive?

Good ●

The service was responsive.

People's care needs were being assessed appropriately.

Person centred care was being delivered.

There was a process and policy for handling complaints.

Is the service well-led?

The service was not always well-led.

There were clear governance arrangements despite there not being a registered manager at the service.

Further improvements were required in tracking and analysing safeguarding concerns, submitting statutory notifications and making the complaints procedure more robust.

Quality assurance systems in place were identifying areas for further improvements which meant they were robust.

Requires Improvement ●

Ablewell Care

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.

The inspection took place on 9 and 10 August 2018 and was announced. We gave the service 36 hours notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection site visit activity started on 9 August 2018 and ended on 10 August 2018. It included talking to staff, talking to people who were receiving a service over the phone, reviewing records including medication administration sheets and visiting people in their own homes. We reviewed three care plans and daily records, visited two people at their own home and reviewed their documentation, spoke with eight staff, four service users over the phone and one person's next of kin.

We reviewed all the information we held about the service including the Provider Information Return {PIR} sent to us dated 6 April 2018. This is a document we ask the provider to complete about the service.

The inspection team consisted of one adult social care inspector.

During a visit to one person's home we met a community nurse who we spoke with and we also contacted other professionals who came into contact with the service such as the Local Authority Contracts and Quality team.

Is the service safe?

Our findings

People we spoke with who were receiving a service told us they felt safe. One person told us "Very safe", a second person said "yes" a third person told us "yes they're wonderful".

We checked the recruitment systems in place and viewed two recruitment files. One of the two files only contained one previous employer reference. We asked the managers about this and we were informed they had identified seven recruitment files where only one reference had been sought. They were in the process of retrospectively obtaining a second reference for each of the seven staff. We found both files contained evidence of an interview and an application form had been completed. There was a Disclosure and Barring Service (DBS) system in place where staff were required to undergo a DBS check which identified any previous convictions prior to them starting to work with people requiring a service. Previous conviction risk assessments had been undertaken when appropriate.

We viewed the rotas and spoke with staff about the staffing levels. All staff we spoke with told us there were enough staff to ensure people received consistency. There had been missed care visits which occurred on the same day which we looked into. We received a copy of the outcome of the investigation into why this occurred and found there had been a technical issue with the oncall phone which resulted in miscommunication. Therefore, we were reassured by this that any missed visits were being looked into. People we spoke with told us they had not experienced a missed visit and if staff were running late due to traffic or being delayed on a care visit they received a phone call to inform them they were running late. Staff in the office told us they were provided with sufficient time to complete paperwork and their visits to undertake assessments with people receiving a service. We viewed rotas which evidenced the senior staff and managers had undertaken the initial care run to calculate in "real" terms the travel time and ensure they had met each new service user to complete the support plan. This meant staff could consider aspects such as busier times of the day in a particular area in advance of them writing the rotas.

We viewed a recent thank you card from a relative which stated "I just wanted to say thank you very much for helping to take care of my mother in this last year. It made a big difference to me knowing that even if one of the carers was off sick or on holiday there would always be someone else to stand in so I never needed to worry that I'd get a phone call saying "no one's turned up". This meant the service ensured they had enough staff to cover holidays and sickness.

The staff were supporting people with their prescribed medicines. We reviewed the records staff had completed including medication administration sheets. We found staff were documenting when they had administered prescribed medicines including as and when prescribed medicines. The service had a system in place of recording any medication errors and we could see actions were taken following an error occurring. There was a system in place for escalating any concerns regarding medication to the person's general practitioner.

Staff understood safeguarding and knew when to report a concern. Staff we spoke with could tell us about types of abuse they needed to look out for and were aware of their duty to report it. We viewed the

safeguarding file in the office and found there had been 16 safeguarding concerns sent to the safeguarding authority in 2017. The service were reporting various types of abuse such as suspected financial abuse and neglect. The service had a safeguarding and whistleblowing policy for staff to follow.

Incidents were being logged and we could see actions were highlighted following an incident. We viewed there had been 10 incidents which had occurred for July 2018 which had been reviewed by the managers with any actions required. The system of recording incidents was clearly seen in the care records and staff had proactively reported concerns to the office staff. Actions were seen such as for a review of the person's needs. Any concerns regarding staff conduct were being addressed in a fact finding meeting and subsequent investigations. This meant we could see the service had clear disciplinary processes in place.

There was a health and safety file seen which included information such as RIDDOR, safe bathing policy, infection control policy and working alone policy. We viewed infection control practices were being promoted for staff to use during their day to day work. Staff had access to gloves and other personal protective equipment. One person we visited told us "staff always wear gloves when putting creams on".

We checked the system of assessing risks for people and we found individualised risk assessments were being completed in a range of areas including in moving and handling, environmental risk, risk associated with prescribed medication and water temperature risk when supporting people with bathing. We viewed a specific bathing risk assessment for individual people receiving support with bathing which detailed the safe temperature in which to support someone to bathe. Thermometers were being provided for staff to use by the provider.

We looked into the system for recording expenditure for people receiving support with shopping and handling money. There was a system in place of staff signing money out and in for each person receiving support with finances. Expenditure records we viewed had been counter signed. There was a running total to track the amount spent and amount remaining.

Is the service effective?

Our findings

We checked how people's care needs were being assessed and if choices were being adhered to. The three care plans we viewed contained detailed assessments of the person's needs and a person centred plan of care with evidence of choices being recorded. For example, one person's morning care visit written in their care plan stated "On arrival I will usually be in bed, please let yourself in using the key from the key safe. Please also ring my bell to alert me that you have arrived".

We checked to establish if the staff delivering care had the necessary skills, knowledge and training. Staff told us they received training and completed the Care Certificate. This involves staff completing the 15 standards of care booklet recognised as a national standard for carers in line with best practice set out by Skills for Care. We viewed staff training files and could evidence staff had completed the Care Certificate or were working towards it. Staff received mandatory training and other additional training. Certificates seen confirmed a range of training included person centred care, communicating effectively, principles of care and confidentiality, consent, care planning, diversity and equality, moving and handling, fire training, health and safety, first aid, infection control, food hygiene, nutrition and diet, safeguarding adults, MCA, DOLS, dementia. Medication awareness with competency check. Two staff had not completed safeguarding training but had completed the competency section in safeguarding as part of their induction. The manager requested the two staff complete their safeguarding training as a matter of high priority.

Staff told us they were receiving supervision and appraisals. The supervision policy stated staff were to undertake shadowing when they first started and then 3 monthly supervisions after that. On the job observational supervision annually but ideally 6 monthly. We viewed the supervision matrix which evidenced staff were receiving supervision. The staff files contained records demonstrating spot check observations had been undertaken, shadowing, supervisions and appraisals.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked to see if the service was adhering to the Mental Capacity Act 2005 legislation and seeking consent. We found staff had a good understanding of the principles of the Mental Capacity Act and we found entries within care records detailing when staff had sought consent. This meant staff were embedding the principles of the Mental Capacity Act 2005 within their delivery of care.

One staff member who was supporting one person who had a power of attorney (POA) had an awareness of the role of the POA. The carer was aware the person receiving care had the capacity to make decisions for themselves and they routinely asked the person for their consent despite them having a POA. This meant staff were aware of people's right to choose and understood the POA was in place in the event the person's mental capacity became impaired at any time. Another staff member we spoke with described how they had

followed a best interests process for another person.

We looked into if people were being supported to have enough nutrition and fluids to maintain their health and wellbeing. The people told us they were receiving what they needed to eat and drink. Staff were aware to record quantities of food and drinks on a person's food and fluid chart if this was assessed as required. The manager told us they only implemented a food or fluid chart if there was an assessed need to do so. The care plans provided a detailed account of how staff were to support the person with their food and drinks.

People were being actively supported to receive healthcare services. One person who we visited in their own home told us they had sustained a fall with bruising on their back. The person told us the carer who visited the day following the fall asked the person if they could phone the person's general practitioner for an assessment visit due to the bruising. Another person told us how their carer phoned for the doctor when they were unwell and remained with them until the doctor arrived. We spoke with healthcare professionals during our inspection and received positive feedback. One healthcare professional told us how all the staff communicated well with them and one carer in particular "was excellent".

Is the service caring?

Our findings

People told us they felt cared for by the staff and staff treated them with respect. We viewed positive comments written by one relative dated 18.1.18 which stated "May I take this opportunity to thank you and all your staff for all the care and kindness given to my mother over the time you have been looking after her". Another relative we spoke with told us "they're caring to use". A third person we visited at their own home said "they're all very very nice who come", "they go beyond what they need to do". The person went on to explain how the carer who had visited in the morning returned at lunch time to check they were ok as they had felt unwell in the morning. The carer was not expected to check on the person as they were not on the rota and do not usually receive a lunch time visit.

A relative of a person who was receiving a service described how the carers went "over and beyond" in their duties and explained how they had been supported by the staff when they were moving house. The relative said the staff assisted them with arranging the house move and were present in the new home when the person was returning home from hospital to settle them in.

All the staff we spoke with demonstrated they had a positive attitude towards encouraging people to be as independent as possible. Staff could explain how they made sure they knew what people's choices were and were encouraging people to make their own choices. Two people we spoke with told us they had specifically asked for either male or female staff and their wishes were adhered to. This meant people were being listened to. Staff were routinely asking people what they needed assistance with and were only assisting with care tasks the person was unable to manage themselves. For instance, one person told us they decided what they would like for lunch and only wanted the carer to place their lunch on a plate in the fridge. They told us the carers would always ask them which room they wanted to be cleaned on the day they were undertaking cleaning.

People we spoke with told us they were spoken to with respect and their dignity was being upheld. One person told us how the carer would always wave to them as they walked down their path when leaving and closed their gate. Another person explained how the carer always placed a towel over them after they had been supported to have a shower when walking to their bedroom. A relative explained how staff would never talk about another person they were delivering care for which made them feel they were maintaining confidentiality.

We viewed in the records staff were asking people if they needed anything before they left the visit and dignity was being promoted. For example, we viewed a red highlighted sentence in one person's care plan which stated ""please close curtains and blinds when hoisting {name of person receiving care}". The style in which the care plans were written demonstrated empathy and compassion for the person.

We asked the staff if the service promoted Equality, Diversity and Human Rights {EDHR}. Staff members we spoke with had experienced inclusive practices in line with EDHR legislation at the service. Staff had a good understanding of lesbian, gay, bisexual and transgender {LGBT} and how to be flexible in their approach to meet individual needs of people. Although the service were not currently supporting anyone with specific

diverse care needs they demonstrated an awareness of ensuring they adapted their care approach to meet the needs of anyone with LGBT or EDHR specific requirements. The service had policies in place titled "monitoring equal opportunities and diversity policy" and the "race relations policy".

There was no one receiving advocacy services at the time of the inspection but the managers were aware of where to source advocacy services if required.

Is the service responsive?

Our findings

We viewed care plans for three people receiving a service and found their care needs had been assessed in a person centred manner. The detail within care plans was confirming what people's likes, dislikes and preferences currently were. Each care plan we viewed included details about the person's medical history, social background, previous occupation, activities or hobbies they had. For instance, one person's care plan detailed that they enjoyed bird watching from their window. We visited the person in their own home and found there was a bird feeder outside the person's window which they could see. This meant the information in the care plan was current and up to date.

We found all of the care plans we viewed contained sufficient detail for staff to be able to provide person centred care to a good standard. The plan was written from the perspective of the person receiving care. The information in the care plans was being reviewed with the person and their family member who knew them best. The service were in the process of completing the Herbert Protocol for three people which is a protocol which Cheshire police were promoting care providers to adopt for people who may be at risk of becoming a missing person. We viewed the documentation in progress and found the staff were collating person centred information about what the person's favourite places were, specific things about them and who were the important people in their lives. This meant the service were implementing good practices.

The care being provided was responsive to people's care needs. People told us they were receiving their care when they needed it and were consulted before any changes were made. We viewed monthly visit sheets which evidenced staff were reviewing people's care on a monthly basis and were seeking their feedback. One person's care needs had changed and they required a different type of hoist. We checked if their support plan had been updated and found the support plan in place had been updated to include details of the new hoist.

The service were actively seeking people's views and feedback about the service. We viewed a survey which had been conducted in March 2018. The results were 63% rated the service as excellent, 32 % good, 5% fair and nobody said poor. People told us staff listened to them and acted upon anything they raised with them. We looked into how the service acted upon complaints. The PIR stated there had been 20 formal complaints made to the service within the last 12 months since the time the PIR was submitted on 6 April 2018. People we spoke with told us they had not needed to make a complaint and if there was anything they were unhappy about they would talk to the carer or office staff. There was a system in place of recording and investigating complaints. The complaints log we viewed listed the complaint and the outcome. The manager told us they were in the process of reviewing their complaints policy and analysis of complaints to ensure it was as robust as possible.

The service were not delivering care for anyone who was receiving end of life care at the time of this inspection. A policy was in place for end of life.

Is the service well-led?

Our findings

At the time of this inspection there was no registered manager in place. The previous registered manager had left the service on 8 January 2018. The Nominated Individual {NI} had informed CQC they were mentoring and coaching an existing manager to become the registered manager. The provider identified the benefits of mentoring an already existing manager within the service who knew the culture and ethos of the service to ensure the governance arrangements were as robust as possible. Both the NI and new manager were working in the service full time.

We found further improvements were required in identifying trends in safeguarding concerns. Although the Nominated Individual was undertaking quality checks and an analysis of incidents this had not been implemented for safeguarding concerns or complaints. Not all safeguarding concerns reported to the Safeguarding Authority had been notified to us. We found the safeguarding policy was not clearly stipulating when staff needed to report safeguarding concerns to CQC. The provider agreed this needed to be improved to ensure it was robust. We asked the provider to complete statutory notifications to us for all reportable safeguarding concerns. The provider acknowledged there were also further improvements needed in their actual recording of safeguarding concerns to include the analysis of trends in the type of alleged abuse and any outcomes of safeguarding concerns.

Further improvements were also needed to improve the complaints policy and procedure. There was a complaints policy in place and the Nominated Individual clarified they had already identified they needed to ensure it was clear what constituted a complaint. The provider was in the process of improving this and updating their complaints policy.

The provider had ensured robust audits were undertaken. For instance, we viewed a recruitment audit completed by both the Nominated Individual and manager who was being mentored to become registered manager. It had identified there were seven recruitment files which contained one reference only when the policy stipulates two are required. This meant we could identify areas for improvements which were being picked up by the provider's existing governance systems.

There was a clear governance structure within the branch office at Ablewell Care which included senior managers, managers, senior support workers, field supervisors and an administrative assistant. Carers and people receiving a service who we spoke with during the inspection were complimentary about the office staff and told us they were always helpful.

We looked into the culture within the service and found the managers had a "hands on" approach where they delivered some aspects of care including undertaking an initial assessment of the expected travel time for carers undertaking new care calls. This meant the managers knew people's plan of care and in the event carers phoned into the office managers were aware of any practical considerations related to the person's calls. People we visited in their own home and spoke with over the phone told us they knew the manager and senior support worker as they had undertaken their assessment of care or were delivering care.

The Nominated Individual was providing clear leadership at the service and had demonstrated this by

undertaking several quality assurance checks including a Quality Report and Improvement Plan published May 2018. This report clearly set out the outcomes of customer feedback and areas for further improvements in communication, timekeeping and response to complaints. The report summarised the trends in medication errors. This meant the service was seeking continuous improvement and taking action when areas for improvement were highlighted. Staff meetings and senior management meetings were being held and the NI told us they had an "open door" policy. The other staff confirmed this and told us how they were able to raise anything in the office to problem solve or make appropriate decisions with the managers.

The last staff survey took place in July 2017 and focused on four areas; staff rotas/time sheets, health and safety, equality and diversity and training. There were actions seen from this survey. Examples seen included a new procedure where any praise about a carer was logged and feedback given to the staff member to ensure they received positive feedback.

Links were being made across other agencies and in partnership to improve care services for people. We viewed a document titled "Careers and Development in Health and Social Care". The document was aimed to encourage anyone who was considering a career within health and social care to support the care industry.

We viewed numerous policies in place such as confidentiality, medication, MCA, missing persons, safeguarding children, safeguarding, whistleblowing, zero tolerance policy, accidents and injuries, reporting of incidents, monitoring equal opportunities and diversity policy, race relations policy, good governance policy, care certificate policy, prevention of extremism and radicalisation. This demonstrated there was leadership within the service.