# Ashwood Home Care Limited

# Ashwood Care

## Inspection report

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Date of inspection visit:
24 July 2018
25 July 2018
26 July 2018

Date of publication:
01 October 2018

## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Good** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Good** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

We carried out an announced inspection of Ashwood Care on 24, 25 and 26 July 2018. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and specialist housing. It provides a service to older adults, younger adults and people with dementia, mental health conditions, sensory impairments and physical disabilities.

Not everyone using Ashwood Care receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection, the service offered support to 170 people who lived in the local authority area.

During this inspection we found two breaches of regulations in relation to safe care and treatment and good governance.

Medicines were not consistently administered in a safe way. Some medication administration records (MAR's) had no dates recorded on them. One person had missed a supplement for one week, another person's medicine had been started but had ran out. There were missing signatures on some MAR charts. One person's medicines were all crushed and mixed with water and taken in a syringe but there was no mention or reference to this process anywhere in the MAR or care notes. When visiting people at home we found a strip of one medicine had been placed in a box of a different medicine, which meant the person could have been given the wrong medicine at the wrong time. Some MAR's contained handwritten information on the back which was poor practice and confusing to understand.

These issues meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because medicines were not consistently managed safely. You can see what action we told the provider to take at the back of the full version of the report.

Although medicines were audited and staff were subject to observations of practice and spot checks these interventions had failed to identify the issues we found during the inspection regarding the safe management of medicines.

These issues meant there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance. You can see what action we told the provider to take at the back of the full version of this report.

There was a registered manager in post. 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 and their relatives told us they felt safe receiving support from Ashwood Care and staff understood the principles of keeping people safe.

Recruitment processes were robust and ensured that staff were of suitable character to work with vulnerable people.

Care files contained risk assessments which determined the level of risk and the control measures required to manage the risk.

There was an appropriate, up to date accident and incident policy and procedure in place. Records we saw indicated no serious accidents had occurred.

People told us they considered staff to be knowledgeable and skilled in meeting their needs and confirmed the care workers and other staff they met were competent. Staff told us they had enough time when visiting people to effectively meet people's needs and people told us staff stayed the full length of the visit but could sometimes be late.

Newly recruited staff were required to undertake a probationary period before being offered a permanent position, which included observed practical assessments before confirmation in their role. Staff induction was aligned with the requirements of the Care Certificate, where appropriate. Staff were receiving the appropriate range of training to enable them to carry out their job effectively.

Staff we spoke with confirmed they received regular one to one supervision and told us that any problems were quickly sorted out.

The service gave people the appropriate support to meet their healthcare needs. Staff liaised with healthcare professionals to monitor people's conditions and ensure people health needs were being met. People stated they were offered a choice of food and enjoyed the food provided.

Staff told us that if they had any concerns about the capacity of a person using the service, they would contact the office. We saw where people lacked capacity this was clearly recorded within their care plan.

People who used the service and their relatives told us care staff were kind, caring and helpful and treated them with respect. Most people using the service and their relatives felt the care staff were approachable, listened to them and acted in accordance with their wishes. Most people we spoke with told us staff respected their privacy and dignity and felt they encouraged them to be as independent as possible.

We found the service aimed to embed equality and human rights though good person-centred care planning. People's confidentiality was protected. Records containing personal information were being stored securely.

People we spoke with who used the service and their relatives confirmed they had been involved in planning their care and each person who used the service had a care plan in place that was personal to them. People could receive information in formats they could understand such as in easy read or large print.

The provider had a complaints policy and processes were in place to record any complaints received. People we spoke with told us that they knew how to complain and had details of how to make a complaint.

End of life care had been discussed with people who used the service, where they agreed to discuss this and

staff had received training to enable them to support people as part of a multi-disciplinary team when required.

The staff we spoke with spoke positively about how the service was run. Staff told us the registered manager was supportive and considered their welfare.

We saw that staff meetings were held regularly and staff had the opportunity to raise any issues. We saw spot checks and direct observations were carried out with staff to ensure that standards of care were maintained.

The service's aims and objectives were referenced in the statement of purpose and were based on offering a professional and effective service to the people who used it and acting as a good employer to staff.

We found the service had policies and procedures in place, which covered all aspects of service delivery

The registered manager, who was supported by an operations manager, worked with the local authority and other professional services to develop and drive improvement.

Results of the most recent questionnaires and surveys received where mostly complimentary about the service, but some people or their relatives had concerns about some staff who they told us did not always understand their care needs.

There was an up to date provider and manager registration certificate on display in the office premises along with an appropriate certificate of insurance.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Medicines were not always managed safely.

People told us they felt safe living at the home.

There were safe procedures for the recruitment of staff and sufficient numbers of staff on duty.

### Is the service effective?

**Good**

The service as effective.

People we spoke with felt care staff were competent.

Staff told us they received an induction and on-going training to ensure they had the necessary skills to meet people's individual needs.

Staff we spoke with confirmed they received regular one-to-one and group supervision.

### Is the service caring?

**Good**

The service was caring.

People who used the service and their relatives said they were treated with kindness and care and comments we received about the service were mostly complimentary.

We found the service aimed to embed equality and human rights through the process of person-centred care planning.

People were encouraged to express their views and to be involved, where possible, in making decisions about their care and treatment.

### Is the service responsive?

**Good**

The service was responsive.

People we spoke with who used the service and their relatives confirmed that they were involved in planning their care.

Visits to people's homes were not rushed and all people we spoke with confirmed this was the case.

We saw that people's care plans and needs were regularly reviewed which was completed with the involvement of people and their relatives, where possible.

## Is the service well-led?

**Requires Improvement**

Not all aspects of the service were well-led.

Audits which were carried out regularly had not identified the concerns we found during the inspection in relation to medicines.

Staff felt the home was well-led and told us the registered manager and other managers supported them well.

People were asked for their views about the service.

# Ashwood 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 was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

This announced inspection was carried out on 24, 25 and 26 July. The inspection was announced to ensure it could be facilitated on that day. The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC), one pharmacist special advisor (SPA) and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service; the expert was experienced in dementia care in a residential and community setting. The service had not been inspected since it re-registered with the Commission at the present location address in December 2016.

Before the inspection we reviewed any information we held about the service in the form of notifications received from the provider. We also reviewed any safeguarding or whistleblowing information we had received and any complaints about the service. We liaised with stakeholders who were involved with the service including the local authority. This helped us determine if there might be any specific areas to focus on during the inspection. Prior to the inspection the service completed a Provider Information Return (PIR), which is a form that asks the provider to give some key information about the service.

At the time of the inspection the service provided care and support to approximately 170 people in the surrounding area. As part of the inspection we spoke with the operations manager, two care coordinators and four staff members. We also spoke with seven people who used the service and eight relatives; this was to seek feedback about the service provided from a range of different people and help inform our inspection judgements. We also visited four other people who used the service in their own homes and looked at how their medication was handled and reviewed their care plan and communication log.

During the inspection we viewed 10 other care plans in the office premises, five staff personnel files, policies and procedures and other documentation relating to the running of the service, such as satisfaction surveys, complaints, spot checks/observations and audits.

Requires Improvement

# Is the service safe?

## Our findings

Both people using the service and their relatives we spoke with told us they felt safe and free from bullying in their homes because of the care and support provided by Ashwood Home Care. One person said, "Yes I'm safe because the carers are very nice." A second told us, "Yes I am safe, the girls are absolutely great. Before they go they check the back door and windows are locked. Everyone [carers] says to lock my door and they won't go until they have heard the door click." A third commented, "They make me feel safe, as I may not see anybody else all day. It is nice to know they are coming."

Comments from relatives included, "Yes, they are very careful when they do things, they are dead gentle with [person name]," and "Yes definitely safe, the carer is very good with [person name]. He can be unsteady on his feet but I feel quite confident with the carer," and "I do feel my relative is safe and if there is any problem they will ring me."

During the inspection we checked to see how the service protected vulnerable people against abuse. We looked at staff training records and found that all staff had undertaken safeguarding training as part of the induction process or thereafter. Staff we spoke with understood the principles of safeguarding adults and children, one staff member said, "I've just recently done safeguarding refresher training. Safeguarding is about ensuring people are receiving safe care but it could also be about financial abuse, neglect or even sexual abuse. I would report any concerns I have to my line manager but I also know I can go to CQC or the local authority if I was concerned about my manager." A second told us, "Safeguarding is a process to ensure people are safe when receiving care and abuse could be psychological, financial or physical. I would always report any concerns to the office and we have an on-call system in case it was at weekend."

The service had appropriate systems and procedures in place which sought to protect people who used the service from abuse. The service maintained a log of any safeguarding's; there was an up to date safeguarding policy in place and local authority alert guidance. Staff confirmed they had read and understood the safeguarding policy which was further supplemented by a whistleblowing policy and procedure which told staff what action to take if they had any concerns. Staff told us the policy and procedure was covered in training. One staff member told us, "I've done whistleblowing training and if I was concerned about a colleague I would tell the office but I could also contact CQC or the local authority." A second said, "I did whistleblowing training at the beginning and it's about raising any concerns you have; I would go to the registered manager first but if I was concerned about them I would go to the operations manager or CQC."

We looked at a sample of 10 care files to understand how the service managed risk. Each care file included risk assessments which covered areas such as falls, food hygiene, moving and handling, nutrition and hydration, general health, the physical environment in the home and equipment used. This risk assessments determined the level of risk and the control measures required to manage the risk. We found these risk assessments were reviewed annually or as required in response to changing needs of the person who used the service.

We looked at how the service managed accidents and incidents. There was an appropriate, up to date accident and incident policy and procedure in place which was supported by additional policies and procedures such as control of substances hazardous to health (COSHH), environmental management, falls prevention, fire safety, first aid, health and safety, infection control, lone working. Incidents were logged and tracked including the date of the incident the name of the person concerned and the action taken to reduce the potential for repeated events. Records we saw indicated no serious accidents had occurred.

Some people who used the service lived alone and staff required the use of a key to access their house. We saw the keys were appropriately stored in a 'key safe' outside each house we visited. This required staff to enter a pin code before gaining access to the key so they could go in and deliver care safely.

During the inspection we reviewed the number of staff in post and found this to be sufficient to meet the needs of people using the service. We spoke with staff who told us they felt staffing numbers were sufficient and they could fulfil all the home visits allocated at the agreed time. Staff travel time had been built into the rotas to assist them to have sufficient time between visits.

Staff were provided with a mobile device used for call monitoring purposes, which they used to log in and out at every home visit; this was linked to the electronic scheduling and care planning system called Care Planner and meant they did not have to use the home phone of the person they were supporting. The electronic system allowed the registered manager to see the start and finish times of home visits in real-time, which meant they could track calls as they happened and contact staff immediately if a discrepancy in the timing of visits was noted. This protected both the staff member and the person being supported.

We looked at the process of recruitment and sampled five staff files. All had appropriate recruitment records including proof of identify and address, at least two references, completed application forms and a disclosure and barring service (DBS) check. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. Staff we spoke with confirmed they had been subject to these checks. This demonstrated the service had followed safe staff recruitment practices.

We looked at how people's medicines were handled to determine if they were given safely and found several errors in the documentation we reviewed. We looked in detail at medication records logs for seven people for May and June 2018. We checked medication administration records (MAR's) and medication audits, staff induction training assessments for four new employees, medication administration training information and medication policies and procedures.

All the MAR charts we reviewed had no dates recorded on them and therefore there was no knowledge of which month they referred to. There was also no structure to the way staff were recording information on the rear of MAR charts.

One person had missed a calcium supplement for one week but there was no information recorded to identify what action had been taken in response. We found handwritten entries on MAR's for rescue medicines needed for an acute infection or breathing problems but these were not signed or dated and there was no indication that the staff making the MAR entry understood the use of these medicines.

Another medicine used to treat anxiety disorders had been started in June 2018 but had ran out; we saw the office had been informed but no other action in response to this was recorded. We found more handwritten entries for anti-inflammatory medicines and other medicines used for anxiety and tension and none of these were signed or dated. Notes had been made about these new medicines but there was no mention about the need to take one of these with food, which is very important to ensure a therapeutic dose is received.

Poor practice was noted regarding the recording of another person's medicines. Inhalers taken had been previously entered on the rear of another MAR chart due to a lack of space. One inhaler from hospital had finished and staff then began the use of another inhaler which had the same drug ingredients but this should have been referred to the prescribers; the change in inhaler was recorded in notes and discussed with the person's relatives. A course of anti-biotic medicine had been written in a grid on the back of the person's MAR chart which is poor practice.

We looked at medicines audit records for 10 people for June 2018. Records of staff non-compliance to company policies or processes were identified but there was no record of which carer was involved and the actions taken to ensure these errors were not repeated.

Shortly before the date of the inspection we found four new staff had undergone induction training for five days; one day comprised of medicines administration. When visiting people at home we checked the stock of people's medicines and found a strip of one medicine used to treat high blood pressure had been placed in a box of a different medicine used to treat digestive problems, which meant the person could have been given the wrong medicine at the wrong time.

For another person we saw three medicines were identified on their MAR chart but the person described to us that these were all crushed and mixed with water and taken via a syringe. There was no mention or reference to this process anywhere in the MAR's or care notes. Whilst this is not innately dangerous, it could have been so if not assessed properly because the therapeutic effect of some medicines can be reduced when in soluble form.

Home care agencies do not normally provide their own MAR charts, but it can be very helpful to ensure continuous care and better records. By transcribing information from GP or pharmacy records onto MAR's, there is far more opportunity for error and if staff carrying out such tasks are not medically trained, they could expose people to extra risk; handwriting MAR entries transfers potential liability to the carer involved if there are any medication errors.

These issues meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because medicines were not consistently managed safely.

We looked at infection control practices within the service. We asked people and their relatives if staff wore personal protective equipment (PPE) when necessary. Everyone told us they had no issues with hygiene, with gloves and aprons being consistently worn as required and disposed of safely in people's homes. Stocks of PPE were available in the office premises which we saw during our visit. Staff were aware of precautions to take to help prevent the spread of infection. For example, staff said they would wash their hands regularly and use aprons and gloves when supporting people in their own homes.

The office premises were safe for staff to use. Fire extinguishers had recently been tested and all electrical equipment had been recently subject to portable appliance testing (PAT) and was deemed safe. The water system was free from any contamination and risk assessments covered areas such as manual handling, slips and trips, electric shock, fire safety and arson.

There was a business continuity plan in place which provided information to staff on the actions to take in response to an unforeseen circumstance such as flu pandemic, loss of office premises, loss of utility supplies, loss of IT/telecoms, loss of staff, fuel shortages and severe weather.

Good

# Is the service effective?

## Our findings

There was a positive response when we asked people and their relatives if they considered staff to be knowledgeable and skilled in meeting their needs. However, three people/relatives raised concerns regarding non-regular care staff. One person said, "The [new carers] introduce themselves and I have to go through the whole rigmarole in telling them what to do. They used to send someone with new carers but not now. I get out of breath when I have to talk to them." A second told us, "Some of the young ones you have to prompt them a bit, the regular ones know what they are doing. Sometimes I don't remember to tell them to put cream on my legs."

People we spoke with and their relatives confirmed the care workers and other staff they met were competent. One person told us, "I've never had a missed call, sometimes they are running late due to road conditions. In the evening they can be late up to half an hour; it isn't a problem as I am always here." A second person said, "Yes, the carers come in and get the job done and do what I need them to do." A third told us, "My carers are absolutely wonderful, if I want anything at all they are fantastic."

A relative commented, "I do think they are quite good with [person name]. They tell her things and they will sit and explain, she listens to them." A second relative told us, "They [the service] have been helpful and explain to us what we can do to get the equipment we need." A third said, "It works brilliantly with the regular staff; they know [person name] well, know where everything is, know what to expect from [person name] and they chat with her."

Staff told us they had enough time when visiting people to effectively meet people's needs. One staff member said, "I feel we have enough time with people and if I need more time on any particular day I ring the office and tell them; I've never been under pressure to rush people, my rota is not crammed and I always get travel time in between."

We looked at staff training records, which included details of training previously undertaken and dates for when training was due for renewal. Training offered to staff included medication, control of substances hazardous to health (COSHH), catheter care, communication, dementia awareness, safeguarding adults and children, stoma care, dignity in care, emergency aid, first aid, end of life, equality diversity and inclusion, food safety nutrition and hydration, fire awareness, medication, infection control, moving and assisting, personal care, the mental capacity act and deprivation of liberty safeguards (MCA/DoLS) and percutaneous endoscopic gastrostomy (PEG). This gave us reassurance that staff were receiving the appropriate range of training to enable them to carry out their job effectively.

Newly recruited staff were required to undertake a probationary period before being offered a permanent position, which included observed practical assessments before confirmation in their role. Staff were also required to familiarise themselves with the people using the service by reading care plans and spending time in their company. Induction also included a range of basic mandatory training and staff were required to read certain policies as part of this process. If a new staff member had not previously worked in social care, their induction was aligned with the requirements of the Care Certificate. The Care Certificate is an

identified set of standards that health and social care workers adhere to in their daily working life.

Staff we spoke with confirmed they received regular one to one supervision and told us that any problems were quickly sorted out. However, at the time of the inspection the service did not have a supervision planner for the year in place. Staff could drop in to the office at any time on any day, in addition to attending more formal supervision or team meetings. These processes gave staff an opportunity to discuss their performance and identify any further training they required. We found that staff were encouraged to share their views and opinions through the mechanism of supervision. The service had an up to date supervision policy and procedure in place. One staff member told us, "I get one-to-one meetings with my manager and I've had two or three since I started last year. It's a two-way process and we get positive feedback and I've got the 'employee of the month' award twice." We found staff were also subject to observations of practice during the year and all had an annual appraisal.

Some people were supported with eating and drinking. We asked people if they were effectively supported in this area and received positive comments. All stated they were offered a choice of food and enjoyed the food provided and one person told us they had a specialised diet. One person said, "I tell them what I want. The carers tell me if there are things I need to eat due to the expiry date on the packet. I get ready meals and they put it in them in the microwave and then on plate; I like them." A second person told us, "They take me shopping and they would cook if I wanted them to but I like to do this myself." Relatives also commented positively about meals. One relative said, "They make the food and ask [person name] what she wants. She eats microwave dinners and sandwiches; she is fine with these and likes them doing."

The service gave people the appropriate support to meet their healthcare needs. Staff liaised with healthcare professionals to monitor people's conditions and ensure people health needs were being met. We saw any communication between professionals such as GP's or district nurses was documented to ensure staff supporting people knew of any changes or issues.

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.

The Deprivation of Liberty Safeguards (DoLS) do not currently apply in settings such as domiciliary care where people are resident in their own homes and so any deprivation of liberty may only be undertaken with the authorisation of the Court of Protection. Staff told us that if they had any concerns about the capacity of a person using the service, they would contact the office. We saw where people lacked capacity this was clearly recorded within their care plan.

We asked staff how they sought permission from people before providing care. One staff member said, "I will always ask someone before I do anything and would keep reiterating this until they understood what I was going to do. If the person had dementia I would get down to their eye level and quietly keep asking them until they understood; it may take a few times but it works in the end." A second told us, "I look at the care plans first to see if consent has been given and then always ask them before doing anything. Good communication is essential, if you don't communicate well the person may be frightened. If the person has dementia it can be trickier so I involve their family in any discussions."

Good

# Is the service caring?

## Our findings

People who used the service and their relatives told us care staff were kind, caring and helpful. One person said, "I have a same person most of time and they feel like good friends." A second person told us, "I get on well with them all and they ask if there is anything else they can do for me" A third commented, "They are absolute lovely. They come in the evening, and ask if I want a cup of tea; we have a chat they ask how my day has been and where I have been."

Comments from relatives included, "[Person name] seems absolutely fine with them; two give her hugs and she likes them all," and "Yes I have found that staff are caring and the carer can be very patient," and "The lady carer is very good. I have not seen [person name] as settled as she is with this lady carer."

People and their relatives told us staff treated them with respect. A relative told us, ""Yes the carers are very nice." A second said, "Yes they are lovely, they ask [person name] about things and talk to him, by that I mean they don't make him feel like he it isn't there." A person told us, "They always ask me if they if they can use my toilet." A second said, "Definitely respectful."

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights though good person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed to lead fulfilling lives, which met their individual needs and promoted their independence.

Most people using the service and their relatives felt the care staff were approachable, listened to them and acted in accordance with their wishes. Comments from people included, "Yes I thinks so," and "I would have no one to talk to if the carers didn't come; they make my day," and "Yes they do listen, for example they will water my plants and put the bin out for me," and "Yes, they are kind. They do little extra things for me occasionally like getting milk or the papers."

Comments from relatives included, "The carers talk and listen to [person name] and she gets on them very well with them," and "They are kind and caring. It is their attitude, for example they talk to [person name] rather than me, which is good," and "Always have a chat that makes a difference to our day. There are some days when it does make a big difference," and "The carer returned person name] heart monitor to the hospital for us and we are very grateful for that; they have gone beyond the call of duty."

Most people we spoke with told us staff respected their privacy and dignity. One person said, "They do; in the morning they pull the curtain across when I am having a shower." A second commented, "Yes they do, before I go to bed they go and shut my curtains and window for me." A third told us, "I am happy with how they treat me. They knock on the door when they come in."

The people we spoke with and their relatives all felt the staff encouraged them to be as independent as possible. One relative said, "I am always there when the carer gives medication to [person name]. The carer

encourages [person name] to be involved and very often he asks what they are for and she will tell him." A person told us, "They take me shopping so I can choose what I want and they would cook if I wanted them to but I like to do this myself. I go out and they chat to me about where I have been." Comments from other people included, "They know l am independent, they [carers] don t take-over," and "I like to be independent, the carers let me do things for myself, within reason," and "Yes, I can do a lot for myself. They ask if I need help and encourage me to do as much as I can for myself," and "They respect my independence and they do the things I ask them to do," and "I try and help myself much as I can. They encourage me to try and do things. When I can't they help and I appreciated it."

We observed that people looked clean and well cared for when we visited them at home. People told us that staff ensured they were dressed in clothing of their choice.

Whilst we did not observe staff providing personal care when we visited people, staff did give appropriate examples of ways in which they would ensure people's dignity was maintained; for example, by ensuring curtains and doors remained closed whilst supporting with personal care tasks.

People's confidentiality was protected. Records containing personal information were being stored securely. Where information was stored on computers this was password protected to prevent unauthorised access.

Good

# Is the service responsive?

## Our findings

People we spoke with who used the service and their relatives confirmed that they had been involved in planning their care which considered the support people required and what they could for themselves. People we spoke with told us when their care was planned at the start of the service staff from Ashwood visited them and spent time finding out about their preferences, and needs and how they wanted their care to be delivered. One person told us, "When I started I told them exactly what I wanted and didn't want and they did this. All is in the care plan and I can choose what I want to use in it. They have been once or twice to see if I needed anything else [review]; they look after me." A relative said, "Yes, [staff name] comes and talks to me. They came down at first and had a chat with me and they have rung a couple times to see how it is going."

The initial assessment also included information about any risks and support was sought from other relevant professionals. This helped to ensure that people's needs could be met by the service.

It was clear from speaking with people who used the service that there was an emphasis on not rushing the delivery of care, ensuring people were comfortable with all activities agreed and undertaken. People we spoke with told us they never felt rushed and staff stayed the full length of the visit although sometimes staff could be late. Comments received included, "I can set my watch by the carer," and "They are on time, once or twice they have been late, they ring up and let me know," and "Never had a missed call," and "Yes, they come on time, occasionally they are late but someone comes within quarter of an hour," and "Never had a missed call, sometimes they are running late due to road conditions but it isn't a problem as I am always here."

Staff we spoke with also felt they were not rushed when supporting people. One staff member said, "We are given time in between calls to go from one place to another; I have a small geographical area to cover so I walk to my calls." A second said, "They [the office] don't bombard you with calls and so you enjoy it better; I feel we get enough time with people and plenty of travel time in between visits." A local authority professional who monitored the service said, "Ashwood are very responsive when we receive client concerns and where actions are required it is done immediately."

Each person who used the service had a care plan in place that was personal to them with copies held at both the person's own home and in the office premises. This provided staff with guidance around how to meet their needs, and what kinds of tasks they needed to perform when providing care. The structure of the care files was clear and made it easy to access information.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We found the provider was meeting this requirement by identifying, recording and sharing the information and communication needs of people who used the service with carers and staff, where those needs related to a disability, impairment or sensory loss; this meant staff understood how to best communicate with people. People could receive information in formats they could understand such as in easy read or large print.

The provider had a complaints policy and processes were in place to record any complaints received and to address them in accordance with their policy. The service dealt with any complaints appropriately which included brining staff into the office to talk about the complaint, where applicable. Records were comprehensive and included any statements from staff involved. There was an index log of complaints received, the document reference number, the name of the investigating officer, the date of resolution and any activities linked to the complaint.

People we spoke with told us that they knew how to complain and details of how to make a complaint were contained in the 'customer information guide' given to all people at the start of service. One relative told us, "We had a young carer that [person name] couldn't get on with, as she was a bit abrupt. I had a word with the office and they changed the rota. I am absolutely happy with how they dealt with this." A second said, "[Person name] gets on very well with the carers. There was one carer who [person name] didn't on well with so we raised it and they did not send her again; [person name] is happy with it now."

We found end of life care had been discussed with people who used the service, where they agreed to discuss this and staff had received training to enable them to support people as part of a multi-disciplinary team when required, such as district nurses. The service did not deliver end of life care directly and at the time of the inspection, the service was not involved in supporting any person or relevant professional in providing care for people who were at the end stages of life. A local authority professional who monitored the service told us, "We facilitated some end of life training which they [the service] are cascading to all staff to a very high standard."

Requires Improvement

# Is the service well-led?

## Our findings

The staff we spoke with spoke positively about how the service was run. One member of staff said, "I like working for Ashwood because the managers listen to me an act on what I say. Team meetings are useful and the on-call system is always available; they either come out to support you or give advice over the phone." A second told us, "[Manager name] is the best boss I have ever had. She is very fair and if you have a problem she will sort it out straight away. All the office staff are nice to all of us."

There was an 'on call' system in place, available every day and night, to ensure that staff could get support from a senior member of staff in the event of an emergency of if they needed advice and guidance. Staff we spoke with said the on-call system was effective and that someone was always available to support them. This showed that effective support measures were in place to assist staff and people in emergency situations.

We saw that staff meetings were held regularly and staff had the opportunity to raise any issues and discussions took place regarding individual people who used the service as well as training, planning, documentation and confidentiality. Staff told us they found these meetings to be useful. One staff member said, "We get regular team meetings and we can bring up ideas and discuss things; we get the notes of the meeting afterwards."

We saw spot checks and direct observations were carried out with staff to ensure that standards of care were maintained. We looked at a sample of these and determined they were carried out regularly and where issues were noted, staff discussed these with their manager or attended additional training. Any action taken regarding staff performance issues was also recorded. One staff member said, "We all get regular observations of practice to test if we are competent as well as spot checks and observations of medicines administration."

We looked at systems of audit and governance and checked the managers audit file; there was an audit spreadsheet in place which identified the date of the audit, the audit type, an analysis of any issues identified and the date of any actions undertaken as a result. A sample of care files were audited each month as well as people's MAR charts, staff files and office files. Although medicines were audited and staff were subject to observations of practice and spot checks these interventions had failed to identify the issues we found during the inspection regarding the safe management of medicines.

These issues meant there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance.

The service's aims and objectives were referenced in the statement of purpose. A statement of purpose is a legally required document that includes a standard set of information about a provider's service. These were the guiding principles which determined how all staff approached their work and were based on offering a professional and effective service to the people who used it and acting as a good employer to staff. These were supplemented by a code of practice which identified people living at home and receiving care should

enjoy the rights and opportunities afforded to all other members of the community.

We found the service had policies and procedures in place, which covered all aspects of service delivery including safeguarding, medication, whistleblowing, recruitment, complaints, equality and diversity, moving and handling and infection control. These policies were all up to date. The service appropriately submitted statutory notifications to CQC.

There were identified lines of responsibility within the service and the registered manager, who was supported by an operations manager, worked with the local authority and other professional services to develop and drive improvement. Feedback from the local authority about the manager was positive and one social care professional told us, "[Manager name] is a very proactive manager and I find her open and transparent. She cares passionately about the services she provides and the low number of complaints we receive reflect this."

Staff told us the registered manager was supportive and considered their welfare. One staff member said, "[Manager name] thinks about staff welfare all the time; she is a good manager. I get one-to-one sessions with them and it's a two-way process. I get positive feedback and have been the employee of the month twice." A second told us, "[Manager name] is a gem, she is lovely and always supportive; they look after you here and I feel it's a good team."

We looked at the results of the most recent questionnaires and surveys and noted comments received where mostly complimentary about the service, but some people or their relatives had concerns about some staff. Feedback received from the most recent annual survey carried out in June 2018 included, 'All carers go above and beyond to help my mum, could not do without them all,' and 'Everything great as getting regular carer,' and 'Very happy carers are fabulous,' and 'Very satisfied, would give all carers a medal.' However, some comments were less positive and included, 'Too many different carers, not safe as too many carers,' and '[Person name] very confused, not happy with several carers, happy with [carer name].'

The manager attended meetings with the Wigan registered managers network and attended 'ethical providers' meetings with the local authority. These meetings provided an opportunity to discuss service development and improvement and we saw discussions had included individual service funds, winter pressures, complaints and compliments, flu prevention, end of life training and CQC updates.

There was an up to date provider and manager registration certificate on display in the office premises along with an appropriate certificate of insurance.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People were not consistently protected against the risks associated with unsafe or unsuitable management of medicines.<br><br>Regulation 12(2)(g) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Audits had failed to identify the issues we found during the inspection regarding the safe management of medicines.<br><br>Regulation 17(1)(2)(a)(b)(c) |