A1 Nursing & Homecare Agency Limited

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Inspection report

55a Park Road,
Wigan,
Greater Manchester
WN6 7AA
Tel: 01942 496352

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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?	Good

Overall summary

This was an announced inspection carried out on 16 and 20 November 2015. 48 hours' notice of the inspection was given so that the manager would be available at the office to facilitate our inspection. The registered manager was required to leave during the inspection due to unforeseen circumstances, but the care manager was available and facilitated the inspection during both site visits.

A1 Nursing & Homecare Agency Limited is a domiciliary care agency that provides support to adults in their own homes within Wigan and the surrounding areas. At the time of the inspection, 13 people were being supported by the agency. Seven of these people received daily visits by the agency and the remaining six people received intermittent support responsive to their needs. One of the people that was being supported frequently had complex care needs. The agency's office is located near Wigan town centre.

Summary of findings

At our previous inspection on 07 and 12 August 2014, we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Suitable arrangements were not in place for the management of medicines. We found that appropriate arrangements were not in place to ensure medication was safely administered to people who used the service, which could have placed them at risk of harm. We also found that an effective system was not in place to regularly assess and monitor the quality of the service provided.

We asked the provider to take action to make improvements in regards to the medicine management and auditing of the service provision. We found at this inspection that this action has been completed. We found medicines and care plans had been written to reflect the medication policy to ensure medication was administered safely. Competency checks were being undertaken quarterly by the registered manger with staff administering medication so that areas of concern could be highlighted and addressed.

We had previously considered the quality assurance system to be ineffective as it didn't highlight when appraisals or mandatory training was required. In addition, policies and procedures had not been reviewed or updated for some time. We saw that there was now a matrix for care workers to show when they had completed training, competency checks and appraisals. However, policies and procedures were not dated so we were unable to determine whether they had been reviewed or updated to reflect current best practice.

Incidents and accidents were documented and we saw that families were informed and actions had been documented to mitigate risks. A system had been implemented to review the quality of care provided which was achieved through the care manager and registered manager conducting audits.

People had a full assessment of their needs prior to the commencement of the service and the care plans devised following the assessment process were person centred and comprehensive. Care workers demonstrated a commitment to providing person-centred care and demonstrated an excellent understanding of people's individual needs.

Staff received an induction, basic training and additional specialist training to meet the needs of the person they supported.

Should people lack mental capacity to make specific decisions, the service was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests.

People's nutritional needs were identified and being met. Information about health and social care professionals involved with people's care and treatment was recorded so care workers could access their help if required.

We found the service had suitable safeguarding procedures in place, which were designed to protect vulnerable people from abuse and the risk of abuse. We reviewed a sample of recruitment records, which demonstrated that staff had been safely and effectively recruited.

Care workers demonstrated a good knowledge of people they supported and provided examples of how they promoted people's independence and maintained their privacy and dignity when providing support.

Care workers told us that they felt the service was well managed and that the care manager and registered manager were available and approachable. We received positive feedback from people we spoke with about the care provided and this was substantiated further through the feedback seen that had been obtained through satisfaction surveys.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Risk assessments were in place to ensure people were safe within their home and when they received care and support.

Medication assessments had been undertaken and care plans were in line with service policy. Care workers ensured that people received their medicines as prescribed.

The service had clear policies in place to protect people from abuse, and care workers demonstrated a clear understanding of what to do if safeguarding concerns were identified.

There were enough staff to deliver care safely, and ensure that people's care calls were covered when staff were absent. When the service employed new staff they followed safe recruitment practices.

Good

Is the service effective?
The service was effective.

Care workers felt supported and were offered regular supervision and appraisals.

People received care from staff that were skilled and trained to deliver care.

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

Good

Is the service caring?
The service was caring.

Care was provided in a caring and respectful way.

People's rights to privacy, dignity and independence were encouraged and valued by staff.

We observed that staff had a good understanding of people's care and support needs and their individual preferences.

Good

Is the service responsive?
The service was responsive.

Care was personalised and delivered in accordance with people's preferences and regularly reviewed.

People were aware of the complaints procedure and felt confident that their complaint would be dealt with thoroughly.

Good

Is the service well-led?
The service was well led.

There was a new care manager in post who had plans in place to improve the service.

Systems were in place to monitor the quality of the service and action had been taken to make the required improvements.

Staff felt supported and positive about the leadership and management.

Good

A1 Nursing & Homecare Agency Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 16 and 20 November 2015 and was announced. We gave the provider 48 hours' notice of our inspection. This was to ensure the manager would be available to facilitate the inspection. The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC).

During the inspection, we spent time at the office and looked at various documentation including five care files for people receiving support and three staff personnel files. We looked at policies and procedures, staff rotas, staff recruitment information, audits, supervision notes, the training matrix and compliments/complaints.

We met one person receiving support at home. We also spoke with two care workers, the care manager and the registered manager. This enabled us to hear what people had to say about the service.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes, which the provider had informed us about. A notification is information about important events, which the service is required to send us by law. We also looked at the Provider Information Return (PIR), which we had requested the registered manager complete prior to conducting the inspection. This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

We also liaised with external professionals including the local authority and local commissioning teams. We reviewed previous inspection reports and other information we held about the service.

Good

Is the service safe?

Our findings

People told us they felt safe with the care workers and trusted them. One person told us, "I receive good, excellent care."

The service had risk assessments in place which reflected people's needs. We looked at five care files and found comprehensive risk assessments which identified the risks and how they would be mitigated. This included risk assessments associated with falls, moving and handling, medicines, nutritional risks, pressure care and a general risk assessment. Where risks were identified, the assessments provided guidance for care workers to follow to minimise the risks. For example, risk assessments indicating that a person was at risk of falls documented the mobility aids used to assist them during moving and handling or mobilising in and outside the home.

The registered manager had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse and whistleblowing processes. The care manager and the members of staff spoken with were able to clearly describe how they would escalate concerns, both internally through the service or externally should they identify abuse and didn't feel it was being actioned appropriately by the registered manager. Care workers had received up to date safeguarding training. A care worker told us; "abuse could be verbal, physical, mental or financial." The care worker informed us of a safeguarding concern that they had raised with the care manager which was currently being investigated by the local authority and had been notified to CQC. Another care worker told us they had received safeguarding training and would be confident to raise concerns with management and that they would be acted on. This demonstrated to us that the service took safeguarding incidents seriously and ensured they would be fully acted on to keep people safe.

We visited one person in their own home and saw that they had a key safe which staff used to enter the premises. This person told us; "They use the key safe system to come in, they always shout to let me know that it's them and they always make sure that my home is secure on leaving." This person also told us that the care workers ensured that care line was switched on when they left. Care line is a 24 hour emergency call system that people access by pressing a button. This demonstrated that care staff ensured people's safety was maintained beyond their visits.

We looked at three personnel files of staff that had been recruited to A1 since we last undertook an inspection. We found that recruitment processes had been strengthened since our last inspection. Appropriate recruitment checks were undertaken before people started to provide care and this was clearly recorded. We saw that checks in each file included: two references, identification checks, and a Disclosure and Barring (DBS) check. The DBS carry out a criminal record and barring check on people who have made an application to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps prevent unsuitable people working with this client group.

We also saw that references for nurses were verified according to Nursing Midwifery Council (NMC) guidelines. The requests A1 made to the referee had been amended to address specific questions regarding the candidate. The interview process had been improved and was consistent across applicants exploring application and CV information. The registered manager was also able to demonstrate that they were monitoring Nurse Midwifery Council registrations and that all nursing staff had up to date registrations.

There were sufficient numbers of care workers to meet the needs of people. We also saw that the care workers were unable to work for the service more than 48 hours per week which meant that staff were not over worked or tired which could result in unsafe practices.

People had consistent care from regular staff. One care worker told us; "There's no problem covering duties. We do 1:1 calls. We are happy to cover each other's absence. There are four of us that are familiar with the person, family and care plans; We cover each other if on leave or sick etc." People told us that their care worker generally visited at the planned times and that they stayed for the agreed amount of time. People said that there had been no instances of any visits being missed. One person told us, "I think there is only a couple of times that they've been late and that was only by about 15 minutes. I understand that the person before me may have needed a little more help that day."

At our previous inspection we had concerns with how medicines were handled. We requested that the registered manager send us an action plan following the inspection to identify how the regulation was going to be addressed. At this inspection, we found that the registered manager had adhered to the medication policy in devising people's care

Good

Is the service safe?

plans. People's care plans included detailed information on the level of support required and also whether the person would be responsible for the administration of their medicines. Risk assessments had been completed for people requiring assistance and or prompting with their medication.

We looked at three medication administration records (MAR) and found that these had been completed appropriately. The MAR displayed a photo of the person and detailed the medication to be administered. We saw protocols were in place for the administration of PRN 'as required' medicines. The PRN medicine dose, frequency and route were written on the MAR. The care plan also detailed the use of PRN medicines so staff had clear information to refer to which would promote consistency between care workers in the administration of medicines. The registered manager also had procedures in place for staff to follow for a person receiving warfarin in the event of them requiring emergency services.

The registered manager regularly audited the medication administration records (MAR). This was to ensure records were being safely and accurately maintained to ensure people had received their medication as prescribed. Medication administration training sessions and refresher training in medication administration were provided. Care workers told us that the registered manager conducted competency checks to monitor care worker's practice when administering people's medication and we saw completed competency assessment forms to confirm this.

The service kept a record of accidents and incidents. From the records looked at we saw that the care manager and registered manager reviewed accidents and incidents so that any patterns could be identified and action taken to prevent re-occurrence. We saw that risk assessments had been updated and this evidenced that the care manager and registered manager collectively monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed.

Good

Is the service effective?

Our findings

One person told us; “They are very good. They all know what they are doing.”

We looked at the training and professional development staff received to ensure they were fully supported and qualified to undertake their roles. We found that all new members of staff undertook a comprehensive induction programme, which included three days of mandatory training with associated workbooks for completion. Following this, new care workers shadowed more experienced care workers until they felt confident to undertake their role independently.

Care workers told us there was a rolling programme of training, which included mandatory training, such as: safeguarding, medication, food hygiene, moving and handling, infection control and fire safety. Training records were difficult to view as there was no overarching training matrix but the care manager was able to demonstrate that individual records were held electronically which they were able to monitor by manually accessing the record. We looked at seven care worker training records, which were selected at random. We found that they were all up to date and indicated when refresher training courses were required to allow staff to develop their skills and knowledge. One care worker told us they were also able to access individual specific training to help them effectively support people with particular medical needs that they had not encountered before.

The care manager expressed a commitment to staff training. Additional training had been sought and we noted nine care workers had obtained a National Vocational Qualification (NVQ) Level 2 and Level 3 in Health and Social Care. One care worker told us; “We watched all the DVD’s and completed training forms before providing support. A1 are currently supporting me to do my NVQ 3.”

The care staff spoken with did indicate that they felt the training DVD’s needed updating and that they would benefit from new material to extend their knowledge. We discussed this with the care manager who agreed and confirmed they were already addressing this with the directors to obtain new training aids and to further strengthen the training programme.

Care workers received ongoing support and professional development to assist them in their role. The care manager told us that staff received supervision quarterly and an annual appraisal. Competency assessments were also undertaken to ensure care workers maintained their ability to undertake the role. We saw copies of supervision records and staff we spoke with confirmed they received supervision and appreciated the opportunity to discuss their role and any concerns. One care worker told us; “I’ve been observed looking after the client and I’ve had regular supervision. I’ve received feedback from the care manager quite regularly. I don’t expect a pat on the back but it’s been positive to receive feedback on my work.”

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application needs to be made to the Court of Protection for people living in their own home.

At the time of our visit there was nobody receiving support that was subject to a court order.

The care workers had received MCA training and the care workers spoken with demonstrated a good understanding of the Mental Capacity Act. One care worker told us; “The Mental Capacity Act relates to people that are deprived of their liberty.” Staff understood the importance of gaining consent from people before providing care. In people’s care files it was documented whether people could verbally consent or whether consent was obtained through expression or sign language. One care worker told us; “Consent is recorded; we always ask first and explain what we are doing. If I had any concerns about someone’s capacity, I’d report it to the care manager.”

Two people were identified as not having capacity to make certain decisions, but it was evident from the care files that they had family members who were actively involved in their care and best interest decisions made on their behalf. As a result, the service had not been required to access advocacy services.

Good

Is the service effective?

We looked at how the service supported people to maintain a balanced diet. Care plans detailed guidance on the support each person required in respect of food, drink and nutrition. We looked at five care files and saw that one person had food and fluid charts in situ to monitor intake. We saw that another person required a soft diet and that care plans had been devised following Speech and Language Therapy (SaLT) assessment and recommendations.

Care workers we spoke with gave examples of how they had supported people with their health needs. They told us how they had reported concerns to the office or contacted GP surgeries to alert healthcare professionals of a change in a person's health. Additionally, a care worker told us about the action that they had taken themselves when their concerns for a person's health involved calling the emergency services for assistance. We were told by the care worker that they had informed the care manager of the situation and that the care manager had immediately attended the home to accompany the person to hospital and informed the person's family.

We saw the service worked closely with other professionals and agencies in order to meet people's health needs. Involvement with these services was recorded in people's care plans and included; SaLT, District Nurses, Social Workers and Doctors.

Good

Is the service caring?

Our findings

One person told us; “All the staff treat me well, they’d get told if they didn’t.”

People were encouraged to be as independent as they were able to be. One care worker told us; “I don’t assume people can’t do things. I encourage them and give them the opportunity to try.” A person told us; “The staff encourage me to do things myself. I do my own medication. When we do the laundry, I fold the pillow cases and they help me with the bulky items.”

People’s privacy and dignity was respected by the care workers. We observed a care worker enter a person’s home using the key from the key safe. Before entering they knocked and shouted to the person identifying who they were. The care worker also sought consent to enter the property before proceeding to do so. The person told us that staff always did this and that they supported them in a way which protected their dignity when receiving personal care. Care workers we spoke with told us how they protected people’s dignity by making sure people were dressed and covered appropriately when providing personal care.

We saw that the conversation between the person and the care worker was relaxed and friendly. The conversation flowed naturally and the care worker was knowledgeable about the person, their relationships and upcoming social events. The care worker asked the person if they would like them to do anything whilst they were speaking to us. The person told us; “she’s good, she’s always like this and she makes the best cup of tea.”

Care workers we spoke with had a caring attitude towards people and cared for them as individuals. One care worker expressed concern at taking any leave as the person they supported had become frailer and they didn’t want to be off and cause any upset to the person’s routine at that current time. We were also told of care workers taking a person’s laundry home and doing it in their own time when the person’s washing machine had broken and they were awaiting a replacement washing machine.

We asked people if they felt that staff understood them and their needs and offered them choice in the way their care was delivered. One person said, “They always ask me what I want”. Care workers were able to describe how they met or understood people’s individual needs and preferences. One care worker said; “We get to know people. We talk to them. People know whether they are ready to get up in a morning, what they want for breakfast and how they want their care to be provided.” The care manager told us, “We discuss the service that people want when we conduct the initial assessment. This allows us to find out about people’s preferences and choices. We give people choice about how their care needs are met. This could be the first time they’ve ever received care.”

The care manager was relatively new in post but they told us that they had spent their initial weeks introducing themselves to people who used the service. They told us that they had done this to ensure people knew who they were when they contacted the office and to provide a contact for people if they wished to discuss anything about their care.

People’s confidential records were kept in their own homes and a copy was stored securely within the main office. Only relevant people were able to have access to the records and the registered worked within the guidance of the Data Protection Act to ensure people’s confidentiality was maintained.

Good

Is the service responsive?

Our findings

We looked at five care files and we saw that each person who requested support from A1 had a full assessment prior to the service starting. From the assessment, care plans were developed that covered people's care and support needs. The care manager told us that people were fully involved in deciding what care and support they required. These assessments included information about a range of needs including health, social, care, mobility, medical, religious and communication needs.

The care plans included personal histories, which were captured on the 'me, myself and I' document. This provided information about people's family histories, religion, what people liked and disliked, who was important to the person and how they would like to be supported on a daily basis. The care manager told us; "How can you provide care to a person that you don't know." We saw evidence of discussions captured in people's files. For example, one person had a history associated with boxing and it had been discussed to purchase the person a pair of boxing gloves. Another person had grown up in Southern England and the person's history was captured in their file and it was documented that this person's conversation was reflective of their upbringing. We asked care workers how they ensured they provided person-centred care. One care worker told us; "Before I provide care, I always read the care plans, their history, speak to the person and their family."

We saw evidence that some people had chosen the care workers that they wanted to provide their care, the time of their care, how they wished to be addressed and how they wanted their care to be delivered. The registered manager had told us that new care workers were introduced to people prior to them providing care and support. This was confirmed by care workers and people we spoke with.

People's care was reviewed regularly, and the frequency of reviews depended on the person's assessment and current care needs. For example, one person had quite complex health needs that were fluctuating so their care plan indicated that their care was reviewed monthly. However, we saw that other people's needs were more stable and their care plans indicated that their care was reviewed quarterly or more regularly if their needs changed significantly within that period.

Care workers demonstrated a commitment to people exercising choice and control about how they spent their time. We found that staff offered support and encouragement to people to access the community where people had care hours identified for social support. We saw that one person was supported to attend the cricket club, shopping and restaurants as was their choice.

Information on how to make a complaint was contained in a handbook which was available in each person's home. We looked at the handbook at the home we visited and found that it contained appropriate information. We asked the person if they had ever had to make a complaint and they told us; "I've never had to make a complaint. I'm happy with all that they do for me. I'd feel confident to make a complaint and as I see management often, I've got enough opportunity."

We saw that there had been one complaint since our last inspection which we found had been investigated in the identified timeframes and appropriate actions taken to resolve the issue.

Good

Is the service well-led?

Our findings

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. The nurse manager was currently registered to provide both nursing and personal care. The registered manager was also responsible for training within the service and managing complex care packages.

There was a new care manager in post who had commenced with A1 in October 2015. The care manager told us that on completion of their three month probation, they would be applying to the Care Quality Commission to be the registered person to provide personal care. The registered manager would remain registered for the regulated activity of treatment of disease, disorder or injury.

Care workers told us they had all met with the care manager through supervision and felt positive about the change in leadership. The care manager had drawn up an action plan and commenced addressing areas that had been identified as requiring improvement during our last inspection in August 2014. We saw that the action plan prioritised people's safety and staff support and we found that target dates on the plan had been met.

Care workers told us that they felt the service was well managed and that the care manager and registered manager were available and approachable. They said they felt supported and that they were able to raise issues and concerns at any time. They told us their views and opinions were listened to and that they would recommend working for the service. One care worker told us; "I've never worked for a company that doesn't just see you as a payroll number. The management genuinely care about the staff. If I hadn't come here, I would have left the care profession."

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They reported that they had no concern that management would support them to do this in line with the agency policies. One care worker told us; "The management care, it's not a front, they are genuinely nice. They care about people and staff. They are brave and not afraid to challenge. If I thought they weren't, I'd take it to CQC and other bodies." We were told by care workers that they felt whistleblowers would be protected and viewed in a positive rather than negative light. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services.

We saw that incidents and accidents were identified, investigated and reported appropriately. We saw that an accident was currently under investigation and that the care plan had been updated to reflect the incident. The care manager identified that the management team analysed incidents and that discussion occurred amongst the management team to highlight patterns and trends. This meant that the management team were able to demonstrate that they were identifying and responding to collective themes.

Audits are a quality improvement process that involves a review of the effectiveness of practice. We saw that the care manager and registered manager were collaboratively conducting monthly audits and we saw action plans and timescales to address areas identified had been met. This was a significant improvement on our previous inspection when the registered manager had been unable to demonstrate that audits were undertaken. At that time; nursing registration, mandatory training and appraisals were identified as being negatively affected due to the absence of an overarching monitoring process. We found at this inspection with the implementation of the auditing process that this action has been completed.

Care plans were regularly reviewed and all daily records were brought back to the office and audited before being filed. Spot checks were conducted on people's homes to ensure staff were on time, dressed appropriately and that they delivered care in line with the care plan. In addition, the medication system had been reviewed and risk assessments, care plans and competency checks had been undertaken and were in line with the agency medication policy.

People's views were sought through satisfaction surveys and we saw that the management had checked people were happy with their care by contacting them by phone,

Good

Is the service well-led?

conducting visits and during reviews of their care plans. Results from the surveys and feedback had been analysed and discussed. The results were generally positive and showed that people were satisfied with the care provided.

We saw that the service had a comprehensive spectrum of policies and procedures that covered a wide range of topics including; equality and diversity, medication, safeguarding and recruitment. However, the policies were not dated and as a result the registered manager could not evidence that they had been reviewed or updated or that they were reflective of current best practice. However, the staff handbook had been updated and contained key policies that differed from those contained in the office file. This meant that staff had access to current guidance and as they worked directly with the person they supported and would rarely come in to the office, it would not have negatively impacted upon service delivery.