Apex Companions Limited

Apex Care Bristol

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?	Good

Overall summary

The inspection was announced. We gave the provider 48 hours' notice that we were starting our inspection because we wanted key people to be available. The service was previously called Connect Care. This was the first inspection of this service since it was registered with new providers in June 2014.

Apex Care Bristol provides a 'Live In Care' service to people in Dorset, Hampshire, Wiltshire, Bristol and Wales. They provide a service to suit the specific and individual needs of people with a diverse range of needs. They look after people living alone and also couples. The services provided range from companionship, assistance with housekeeping and support to people with mental/ physical disabilities, frail, and elderly or are at the end of their life. At the time of the inspection the service was providing a service to 35 people.

Summary of findings

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People said they felt safe with the live-in carers who looked after them. The live-in carers received safeguarding adults training and were aware of safeguarding issues and their responsibilities to protect people from harm. Staff knew how to report any concerns. They were recruited following robust recruitment procedures. Management plans were put in place where risks had been identified in order to reduce or eliminate that risk.

People received the care and support they expected and had been involved in agreeing to. Live-in carers were knowledgeable about the people they looked after and received appropriate training and support to enable them to undertake their roles effectively. People were provided with sufficient meals and drinks and were supported to access health care services if needed.

People were looked after by a small number of Live-in carers (maximum of three) and had good relationships with the staff that supported them. People were treated with kindness and respect and were always included in making decisions about their daily lives.

Assessment and care planning processes ensured each person received the service they needed and met their individual needs. Their preferences and choices were respected. People were provided with copies of their plans, knew what service was provided and who was going to support them.

People and live-in carers said the service was well-led and they were encouraged to provide feedback. The quality and safety of the service was regularly monitored and used to make improvements. The service had a plan for making improvements.

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?

Good

The service was safe.

People were protected from abuse and staff had a good awareness of safeguarding issues and their responsibilities to protect people from coming to harm. Staff were recruited following safe recruitment procedures and unsuitable staff could not be employed.

Risk assessments had been completed to ensure people could be looked after safely. People's homes were assessed to ensure they were a safe place for staff to work in.

There were sufficient care staff available to meet the needs of people and new people were only offered help when staff were available.

People were supported with their medicines where required. Staff were competent to support people with their medicines.

Is the service effective?

Good

The service was effective.

People were supported by staff who were competent in their roles. They were well trained and supported to carry out their jobs.

Staff had a sufficient understanding of the Mental Capacity Act (2005) and consent. They knew of the importance for people to make their own choices but knew they had to ensure people were safe.

People were provided with the agreed level of support to eat and drink and maintain a balanced diet. People were supported where necessary, to access the health care services they needed.

Is the service caring?

Good

The service was caring.

People were supported by live-in carers who were kind and caring to them. They were listened to and their views and opinions were seen as important. The support people were provided with was governed by how they wanted to be cared for.

Staff spoke well about the people they were supporting and knew the importance of good working relationships.

Is the service responsive?

Good

The service was responsive.

People were provided with a service that met their care and support needs. Assessments and the delivery of the care and support was personalised to each person.

People were encouraged to have a say about the service they received during reviews, questionnaires or direct contact with the office. People were provided with a copy of the complaints procedure that enabled them to raise concerns if they needed.

Summary of findings

Is the service well-led?

Good

The service was well-led.

People and live-in carers said the service was well managed and the registered manager and coordinator were approachable and helpful. There was a clear expectation that the live-in carers looked after people in the best possible way.

Feedback from people who used the service was actively sought and where improvements were needed appropriate action was taken to address any issues.

There was a range of measures in place to monitor the quality of the service and plan improvements. Learning took place following any accidents, incidents or complaints to prevent reoccurrences.

Apex Care Bristol

Detailed findings

Background to this inspection

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

This was the first inspection of Apex Care Bristol and was completed on 15, 18 and 22 May 2015.

The inspection team consisted of one adult social care inspector.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We had not asked for the Provider Information Record (PIR) to be submitted.

We contacted healthcare and social care professionals as part of our planning process and invited them to provide feedback on their experiences of working with the service. The comments we received have been included in the body of the report. We received a response back from three professionals.

During the inspection we visited three people in their own homes and also spoke with two live-in carers. We spoke with the relative of one other person. We met with the registered manager and care co-ordinator and spoke by telephone to the training manager and four live-in carers.

We looked at four care records, five staff recruitment files and training records, and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe with the live-in carers who looked after them. They said "I feel safe knowing there is always someone there to help me", "They are very kind and good to me", "I feel completely safe and I have never felt worried. Having a carer stay in my house means I don't have to worry".

Staff understood what was meant by safeguarding people, what constituted abuse and what their responsibilities were to keep people safe. All staff had completed safeguarding training but the training manager was in the process of doing face to face refresher training with each member of staff. Safeguarding training was also included in the induction training programme that all new recruits had to complete. Staff had to complete a knowledge-check worksheet in order to demonstrate their understanding.

Those live-in carers we spoke with would report any concerns they had about a person's safety to the registered manager or the care coordinator. There were on-call arrangements in place if concerns were raised in the evenings and at weekends. Staff were less aware they could report concerns directly to the police, the local authority or the Care Quality Commission. People were provided with an information leaflet about abuse and were given an information leaflet with contact details of organisations they could speak to if need be. The registered manager had raised safeguarding alerts on three occasions where there had been concerns about a person's wellbeing.

A live-in carer's risk assessment was undertaken to ensure each person's home was a safe place in which to work. This was undertaken as part of the initial setting up of the service. This ensured that staff were not placed at risk. This assessment covered both the inside and outside of the home, all equipment that the live-in carers needed to use, utility services and the presence of any pets and other family members in the home. Moving and handling risk assessments were completed where people needed to be assisted by their live-in carer staff. The support plans set out what moving and handling equipment was to be used.

The provider had a plan in place to follow in the event of any emergency (Emergency Situation Plan). This set out the arrangements in place in the case of IT failure or any other events that disrupt the safe delivery of the service. We talked about the effects of adverse weather conditions however if the live-in carers were prevented from getting to a placement, the existing live-in carer would be unable to leave. The registered manager talked about an occasion when a live-in carer had a medical emergency and had to leave a placement, and what arrangements were put in place to provide cover.

Staff files showed that safe recruitment procedures were followed at all times. Appropriate checks had been completed and included written references and a Disclosure and Barring Service check. A DBS check allows employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people. The registered manager said it was the providers policy to do random renewals of DBS checks after a period of time.

Apex Care Bristol only provided a service for new people if they had live-in carers available to support them. The registered manager explained all handovers took place on a Tuesday and people were supported by two, or a small number of carers. Live-in carers submitted their availability on a monthly basis and could work for either one, two or three week periods.

The level of support people needed with their medicines was assessed and recorded on their care and support plan. People retained responsibility for their own medicines where this was practicable and safe. If they needed support they provided written consent to be assisted. Staff received training in the safe administration of medicines and on-going competency checks were carried out to ensure medicines were administered safely. Live-in carers we spoke with confirmed the training and the competency assessments. We saw the records of the refresher training that some live-in carers had already completed. People were protected against the risks associated with medicines because the measures in place ensured they were supported safely.

Good

Is the service effective?

Our findings

People said, “I get on very well with the staff”, “They are good at their jobs but I wish they could cook better”, “The staff look after me so nicely. Everything is alright now” and “I only have to ask for something and they help me”. The family we spoke with commented “I have peace of mind because I know my relative is being well looked after” and “They keep in touch with me and tell me how things are going”.

Staff were supported to do their jobs. Any training and development needs were identified during regular supervision meetings or spot check visits by the registered manager, care coordinator or training manager. Records were maintained of all supervisions and spot checks.

All staff were expected to complete a programme of essential training. New live-in carers had to complete a three day induction programme at the head office in Hampshire. This included health and safety (fire safety, basic first aid, food hygiene and infection control), adult safeguarding and the Mental Capacity Act, administration of medicines and moving and handling training. Those live-in carers who had started their employment under the previous provider were being issued with the Apex Care induction programme to complete and some of the live-in carers we spoke with were aware of this. The training manager had implemented a programme of individual face to face training in April 2015 with the live-in carers and had to date completed with 13 of the 61 staff team. The registered manager said that the implementation of this programme had been “more sluggish” than wanted but they were in the process of recruiting a field supervisor to support the training manager.

Thirty-six of the live-in carers had completed a recognised qualification in health and social care at level two or above. The coordinator was in the process of working towards level five and the registered manager had already achieved the registered managers award.

Staff completed Mental Capacity Act (MCA) 2005 training. MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. An assessment of each person’s mental capacity was made in respect of all aspects of care and daily living. The assessments were reviewed when there were changes in the person’s needs. Where people lacked the capacity to make decisions the registered manager said best interest decisions would be made with other key people (family and the GP or other health care professionals) and records kept of those decisions. Live-in carers said they would always ask people to give their consent before assisting them with personal care tasks and allowed the person to make decisions about tasks that needed to be done. One person we visited had a severe memory impairment however said “I like to be asked about things and not just told I have to do something”.

The level of support each person needed with their food and drink was determined during the assessment and setting up of the service. Care records showed people’s needs regarding food and drink had been agreed with them. One person said, “I need a wheat free diet and the staff know what I can and cannot eat”. It was written in one person’s plan “I can say what I would like to eat”. Another person needed to have a good fluid intake each day in order to ensure their urinary catheter functioned well.

People were registered with their local GP surgery and were supported by the live-in carers to see their GP or other health and social care professionals. Where needed the live-in carers worked alongside community and hospital social workers, occupational therapists and physiotherapists in order to make sure people were well looked after.

Good

Is the service caring?

Our findings

People said the live-in carers who looked after them were kind and caring. Comments we received included, “The staff are very kind to me. They are always kind, helpful and willing to do what I need”, “I am very satisfied with the kind way I am treated” and “They do everything for me. I couldn’t ask for kinder staff to look after me but I wish (named live-in carer) was able to come back to me.

Live-in carers spoke about the people they were supporting in a caring and respectful manner. They told us it was important they allowed people to have private time and also to make sure they had time to talk with the person they were looking after. The staff respected people’s privacy and maintained their dignity at all times. People were asked by what name they preferred to be called and any other choices and preferences that were important to them.

Before a service was set up people were visited by the registered manager or the coordinator and an assessment completed. During this process people were asked how they wanted to be supported. Where appropriate family, friends or other representatives advocated on behalf of the person being looked after however the views of the person receiving the service were respected and acted on. If the person was assessed at a time when they were not in their own home (for example in hospital) a visit would be made to the home to ensure it was feasible for a live-in carer to work in that environment.

Health and social care professionals who responded to our request for their views and opinions about the service told us, “This is a really kind and caring service. People are able to form good working relationships with the staff who support them because they have the same live-in carers” and “The live-in carers are very professional and supporting and I have received positive feedback from the person supported and their family” and “I would recommend this service to colleagues because of the way the staff would with us to find solutions to difficulties”.

The service communicated effectively with each person, either in person or through their live-in carer to ensure that they always knew who was going to support them and for how many weeks. People were provided with the live-in carers who alternated their work hours (two weeks on two weeks off) where possible These arrangements were only changed when live-in carer availability differed, for example they could only provide one week.

Good

Is the service responsive?

Our findings

People told us they received the service they expected and met their needs. People said, “I am more than satisfied”, “I get all the help I need”, “The help I get means I am able to stay in my own home. That is what is important to me” and “I have the same staff the majority of the time therefore they know what needs to be done for me”.

People had a choice about who provided their care and support and were encouraged to feedback how they got on with their live-in carer. One person we visited did raise concerns with us that a live-in carer they did not get on with had provided one weeks support recently. We fed back this information back to the registered manager who will review these comments with the person involved. The registered manager and coordinator explained they always “match” the live-in carer to ensure they have the necessary personal qualities and can relate well to the person.

Live-in carers were expected to report any changes in people’s care needs and health to the office and to liaise with health or social care professionals as appropriate. This ensured that the service being provided remained appropriate and people received the support they needed. We looked at the care files held in both the Apex Care Bristol office and in people’s home. An assessment of the person’s care and support needs had been carried out and a personalised support plan had been written. The care plans were informative and detailed the specific support the person needed and how the planned care was to be provided. It was evident that the person had been involved in setting up the service and had been asked to say how they wanted things done.

Live-in carers were expected to read the person’s support plan at the start of the shift to ensure they were familiar with any changes that had taken place since the last time they worked with that person. The live-in carers we spoke with confirmed that they always did and also referred to the handover sheet that had been prepared for them.

All live-in staff were required to write reports throughout the day that were accurate, detailed, factual and continually updated. At the end of their period of work they completed a handover shift for the next live-in carer to refer to. This ensured that important information was passed on. Daily notes are returned to the office on a regular basis, checked to ensure that the live-in carers have completed appropriately and then archived.

People were given a copy of the service user guide and this provided information about the service provided, relevant contact telephone numbers and the complaints procedure. People said, “If I was not happy with something I would ring the office”, “I have regular contact with the office, the office staff are very approachable and willing to listen to me” and “I have absolutely nothing to complain about but would if I need to”.

The service had received six complaints in the last 12 months and records evidenced that the appropriate action had been taken in all cases. The Care Quality Commission have received no complaints about this service.

Good

Is the service well-led?

Our findings

People made these comments when we asked them whether the service was well-led : "I have never been let down so I guess the service is managed well", "I think both the manager and the coordinator are good" and "Everything works well so I don't have to worry". The family member we spoke with was satisfied with the service delivery arrangements as well.

Live-in carers said the service was well-led. The service was currently in the process of recruiting a field supervisor to compliment the staff structure and to provide increased support for the staff team. Live-in carers and people being supported said the registered manager and the coordinator were approachable and there was an on-call system for management support and advice out of hours. Live-in carers said there was always someone available that they could call upon and it worked well. The registered manager and coordinator have on occasions provided cover if the live-in carer became unwell and could not continue to work. Staff said their views and opinions were sought and they were listened to. Live-in carers said they had been given details about the whistle blowing policy and there was an expectation they would report any concerns they had, or bad practice they witnessed.

Because the live-in carers all lived over a wide geographic areas, staff meetings were not possible. However, feedback from the team about how things were going and suggestions about meeting people's needs was encouraged. On a monthly basis all live-in carers were asked to provide the following months availability and were also sent information via a newsletter to "keep them in the loop".

The aim of the service was "to deliver a personal care and associated domestic service to meet the needs of the dependent client in their own home" and "to provide a service of the highest quality to improve and sustain the clients overall quality of life". It was evident from speaking with the registered manager, the coordinator, training manager and live-in carers that this was an aim shared by all.

The registered manager had a clear plan of improvements they intended to make. This included having a third member of staff (field supervisor) in place to support the on-call arrangements and undertake staff supervisions and competency checks, and to increase the availability of staff training.

Survey forms- We Value Your Opinion, were sent out from head office on a six monthly basis to each person supported by the service. People were asked about the live-in carers that support them, respect and dignity and any complaints for example. Where less than satisfactory comments had been made the registered manager responded to these. A letter from the registered manager had been sent to one person who commented "I would only like to have two regular carers" detailing what actions was being taken. The registered manager explained that head office always followed up that some action had taken place in respect of negative comments.

The service had systems in place to ensure the quality was maintained. The registered manager had to submit weekly reports to the managing director in respect staffing, people receiving a service, complaints received and any accidents or incidents. The registered manager analysed any accidents and incidents and complaints to look for trends so that preventative measures could be put in place to prevent or reduce the likelihood of a reoccurrence. The registered manager attended a monthly managers meeting with the other Apex Care branch managers.

The registered manager was aware when notifications had to be sent in to CQC. These notifications would tell us about any events that had happened in the service. We use this information to monitor the service and to check how any events had been handled. In the last year three notifications had been sent in to CQC to make us aware of concerns they had raised with the local authority regarding the safety and welfare people they supported and one notification in respect of an expected death.

All policies and procedures were produced by Apex Companions Ltd and were kept under review. Some of the policies had been adapted to reflect the nature of this service – a 24 hour live-in carer service. Live-in carers were provided with a copy of the staff handbook and this contained a number of key policies. Live-in carers were expected to be familiar with these. Examples of key policies include the health and safety policy, gifts, gratuities and bequests, confidentiality and procedures when supporting people with financial transactions.