Augusta Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

Augusta Care Limited is a domiciliary care agency registered to provide personal care for people living in their own homes. There were 66 people using the service at the time of our inspection. The service covers a wide geographical area including, Cambridgeshire, Northants and Norfolk.

This inspection was carried out on 09 and 10 June 2015 and we gave the service 48 hours' notice of our inspection. Our last inspection took place on 07 May 2014 and as a result of our findings we asked the provider to make improvements to supporting workers. We received an action plan detailing how and when the required improvements would be made by. During this inspection we found that the provider had made the required improvements.

There was a registered manager in place. 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 Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005

Summary of findings

(MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. The management were working with the local authority supervisory body to ensure that appropriate applications would be made to the authorising agencies to make sure that people's rights were protected. Care records we looked at showed that there were no formal records in place to document the assessment of people's individual capacity to make day to day decisions.

People who used the service were supported by staff in a kind and respectful way. People had individualised care and support plans in place which recorded their needs and wishes, and likes and dislikes. These plans prompted staff on any assistance a person may require.

Individual risks to people were identified by staff. Plans were put into place to minimise these risks to enable people to live as independent and safe a life as possible. There were arrangements in place for the management, and administration of people's prescribed medication. However, records which documented the administration of people's medicines was not always completed as an accurate record.

People and their relatives were able to raise any suggestions or concerns that they might have with staff and the management team and feel listened too.

People were supported to access a range of external health care professionals and were supported to maintain their health. People were provided with adequate amounts of food and drink to meet their hydration and nutrition needs.

There were enough staff available to work the service's number of commissioned / contracted work hours. Staff understood their responsibility to report poor care practice. Staff were trained to provide effective care which met people's individual care and support needs. They were supported by the registered manager to maintain their skills through training. The standard of staff members' work performance was reviewed by the management through supervision and appraisal to ensure that staff were competent.

The registered manager sought feedback about the quality of the service provided, from people who used the service by holding service user 'forums' and sending out surveys. There was an on-going quality monitoring process in place to identify areas of improvement required within the home. Where improvements had been identified there were actions plans in place which documented the action taken or to be taken.

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 not always safe.

People's care and support needs were met by a sufficient number of staff. Staff were recruited safely and trained to meet people's care and support needs.

Systems were in place to support people to be cared for safely and to make sure that any identified risks were reduced. Staff were aware of their responsibility to report any safeguarding concerns.

People were given their medicines as prescribed. Accurate records of medicines administration were not always kept.

Requires Improvement

Is the service effective?
The service was not always effective.

Management were working with the local authority supervisory body to ensure that people's rights were protected. No formal documentation was in place to record people's capacity to make day to day decisions.

Where assessed as being required, people's nutritional health and well-being was monitored by staff and any concerns were acted on.

Requires Improvement

Is the service caring?
The service was caring.

Staff were caring and kind in the way that they supported and engaged with people.

Staff encouraged people to make their own choices about things that were important to them and to maintain their independence.

People's privacy and dignity were respected by staff.

Good

Is the service responsive?
The service was responsive.

People were able to continue their interests and take part in individual and group activities and maintain links with the local community.

People's care and support needs were assessed, planned and evaluated. People's individual needs and wishes were documented clearly and met.

There was a system in place to receive and manage people's suggestions or complaints.

Good

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

Good

Summary of findings

There was a registered manager in place.

People and staff were asked to feedback on the quality of the service provided through surveys and meetings.

There was a quality monitoring process in place to identify any areas of improvement required within the service. Plans were in place to act upon any improvements identified.

Augusta Care 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 was planned to check 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 09 and 10 June 2015, was announced. This is because we needed to be sure that the registered manager was available. The inspection was completed by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of working with or caring for someone who uses this type of care service.

Prior to our inspection we reviewed the provider's information return (PIR). This is information we asked the provider to send to us to show what they are doing well and the improvements they planned to make in the service. We also looked at information that we held about the service including information received and notifications.

Notifications are information on important events that happen in the service that the provider is required to notify us about by law. We also asked for feedback on the service from a representative of Cambridge and Peterborough continuing health care team, Peterborough City Council contracts monitoring team, Peterborough City Council adult social care team and a specialist physiotherapist from Norfolk Community Health and Care NHS Trust to help with our inspection planning.

We spoke with six people who used the service and one relative. We also spoke with the registered manager, two team managers, two project leads and three support workers. We observed staff support people who visited the services office during this inspection.

We looked at eight people's care records and we looked at the systems for monitoring staff supervisions, appraisals and training. We looked at other documentation such as quality monitoring records, accidents and incidents records and the business contingency plan. We saw, records of weekly contracted/commissioned work hours, compliments and complaints and medication administration records and medicines policy.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us that they felt safe. One person told us that, "Knowing the support worker is coming in," made them feel safe. Another person who was supported by staff to live independently said, "I feel safe."

People who were able to tell us had no concerns about the way staff managed their medicines. One person said, "Staff measure out my tablets for me. I take them myself." Another person told us how they managed their own medicines. Care records we looked at detailed people's medicines, the reason for the medicine and the most recent medicines review by a doctor. Staff who administered medicines told us that they received training and their competency was assessed. This was confirmed by the records we looked at. Where people had been prescribed medicines to be administered on an 'as required' basis there were clear protocols in place for staff for when this medication should be administered. However, we found in two out of five people's medicines administration records (MAR) that we looked at, there were gaps in the recording with no documented explanation. This meant that there was an increased risk of miss-interpretation of these records by other staff members. This was also not in line with the service's medicines recording protocol which required a documented record in line with their agreed key symbols method of recording. We noted that on one occasion when medication was administered, the actual time it was given was not recorded by staff. This meant that there was a risk of doses of the medicine being given too close together or too far apart.

People told us that if they felt unhappy of worried they would inform staff. One person said that they, "Would let [the] carer know." Another person when asked if staff had ever raised their voice to them said, "Never, Staff are kind to me." Staff we spoke with told us that they had undertaken safeguarding training and records confirmed this. They demonstrated to us their knowledge on how to identify and report any suspicions of harm or poor practice. They gave examples of types of harm and what action they would take in protecting people and reporting such incidents. Staff were aware that they could report any concerns to external agencies such as the local authority safeguarding team and the Care Quality Commission. Care records we looked at showed that where staff helped support people with their day to day spending. We saw specific instructions in place for staff regarding the management of the person's money including the reason for the assistance. We noted that financial records with receipts were completed by staff for each withdrawal. This showed us that there were processes in place to reduce the risk of abuse.

Staff demonstrated to us their knowledge and understanding of the whistle-blowing procedure. They knew the lines of management to follow if they had any concerns to raise and were confident to do so. This showed us that they understood their roles and responsibilities to the people who used the service.

People had individual risk assessments undertaken in relation to their identified support and care needs. We saw that specific risk assessments were in place for people at risk. Risks included not maintaining their own personal care, dysphagia [poor swallowing], bed rails, administering medication moving and handling, and travelling whilst in a vehicle. Risk assessments gave prompts to staff to help assist people to live as independent and safe life as possible. This guidance helped reduce the risk of people receiving inappropriate or unsafe care and assistance. When people were deemed to be at risk of seizures, records were kept to record the frequency. Records were kept by staff so that they could monitor this information and take action where concerns had been identified. This was confirmed by the staff we spoke with who told us about the care and support needs for each person they assisted and understood the risks to people and how to minimise them safely.

A relative told us that, "It's important the carer is always on time because time is very important to [family member]…the carer always calls [family member] on [their] mobile if [staff member] is running late." They said that, "[Family member] phones the carer and arranges what [they] want to do, where to meet and at what time." We looked at two recent weeks of the overall contracted/ commissioned hours of care work the provider had. We then checked the overall hours of staff scheduled availability for that time period. Evidence showed us that there was enough staff available to work, to meet the number of care hours commissioned. Care records we looked documented people's support need of either one or two care workers depending on their individual assessed level of need. Staff that we spoke with told us that they received their work schedules in advance. They were

Requires Improvement

Is the service safe?

notified of any changes to the schedule to cover short term absence in advance via an e-mail from the office. Staff confirmed that the management built in travel time between each care call so they could spend the entire care call time supporting the person and not part of the time travelling. This showed that the provider had enough staff available to deliver safe care and support for people who used the service.

Staff we spoke with said that the provider carried out pre-employment safety checks prior to them providing care. These checks were to ensure that staff were of good character. This demonstrated to us that there was a system in place to make sure that staff were only employed if they were deemed safe and suitable to work with people who used the service.

We found that people had a personal emergency evacuation plan in place and there was an overall business contingency plan in case of an emergency. This showed that there was a plan in place to assist people to be evacuated safely in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

People we spoke with who were able to tell us said that staff respected their choice. One person told us, "It's up to me what I do." Another person told us that staff listened to them and ask for their permission before giving care. Where people had limited vocabulary, we saw that care records we looked at had a communication passport in place to support the person to make decisions. Included in the care records were prompts for staff around understanding people's key words, pictorial aids used and/or body language/ reactions and what these meant.

We spoke with the registered manager about the Mental Capacity Act 2005 (MCA) and changes to guidance in the Deprivation of Liberty Safeguards (DoLS). We found that they were aware that they needed to safeguard the rights of people who were assessed as being unable to make their own decisions and choices. We saw evidence that management had been working with the supervisory body (local authority) prior to making applications to the court of protection to ensure that people's rights were protected. The majority of staff we spoke with showed that they knew how to ensure people did not have their freedom restricted without the legal process in place and to respect people's choices. One staff member explained how you would always assume a person could make their own decisions. They said that, "[People] have [mental] capacity, unless assessed otherwise." Records confirmed to us that the management had provided staff with training in MCA 2005 and DoLS. Care records we looked at documented for staff where a financial appointee was in place to help support the person with financial decisions. However, in seven out of eight care records we looked at there were no formal records in place to document the assessment of people's individual capacity to make day to day decisions. The one care record with a formal mental capacity assessment in place had not been reviewed since December 2013. This meant that formal records were not in place to show that people were regularly assessed for their mental capacity to make day to day decisions.

Staff told us that they were supported with regular supervisions in which they could talk about any topics they wished to discuss. Records we looked at confirmed that supervisions and appraisals happened. Staff said that when they first joined the team they had an induction period which included training and shadowing a more senior member of the care team. This was until they were deemed competent and confident by management to provide effective and safe care and support.

We found that staff we spoke with were knowledgeable about people's individual support and care needs. Staff told us about the training they had completed to make sure that they had the skills to provide the individual support and care people needed. This was confirmed by the registered manager's record of staff training undertaken to date. Training included, but was not limited to, first aid, equality and diversity, safeguarding, MCA and DoLS, autism awareness, infection control, person centred support, moving and handling, epilepsy, challenging behaviour and eating and drinking. This showed us that staff were supported to provide effective care and support with regular training.

People where appropriate, were supported by staff with their meal and drinks preparation. One person said, "I do spaghetti bolognese, sweet and sour chicken, hotpot, lasagne and gammon and mash." Another person confirmed to us that they were able to choose what they wanted to eat. They told us that they were planning on having, "[Breakfast brand name cereal] and a sandwich for lunch." This was confirmed by staff who told us how they involved the person to help prepare the meal prior to cooking. They said how they tried to encourage people to choose the healthy option. Care records we looked at also documented what assistance a person required at mealtimes, what their food likes and dislikes were and their preferred mealtimes.

We saw that guidance was in place for staff in the care records we looked at for people who required their meals to be prepared in line with speech and language guidelines. One staff member we spoke with who supported people at risk of poor swallowing told us that they were aware of the speech and language therapists' guidance. For people who had been assessed as requiring some additional assistance from staff around nutrition, we saw this recorded in people's individual care records. This showed us that people were supported with their nutritional and hydration needs.

External health care professionals including speech and language therapists were involved by staff to provide guidance if there were any concerns about the health of people using the service. One person told us that when

Requires Improvement

Is the service effective?

they felt unwell, “They [staff] take me to the doctors.” Another person said that staff supported them to go to the doctors and attend dentist appointments. Records we looked at confirmed external health care involvement.

Good

Is the service caring?

Our findings

People had positive comments about the service provided. We were told that staff supported people in a kind manner. One person said, "Staff are kind to me… good staff here, [staff] listen to me." Another person told us that, "Staff are kind." A relative we spoke with also had positive opinions about the care and support provided by staff for their family member. They said, "Staff are kind and listen to [family member]." They went on to tell us that, "We didn't have a good start but my faith in the agency has been restored. The carer is absolutely marvellous, [staff member has] become [family member's] friend but knows the boundaries." Care records we looked at documented for staff guidelines on how to work with people they were supporting in a positive manner. This was confirmed by our observations of staff supporting people when visiting the service's office.

Care records we looked at were written in a personalised way which collected social and personal information about the person, including their likes and dislikes and individual needs. Records showed that staff must have got to know the person and how they wished to be supported before writing up the care and support plans. A relative told us, "At the beginning, staff from the agency came round to get a good idea of what [family member] likes to do." This was so that staff had a greater understanding of the person they were supporting. However, the care records we looked at did not have documented evidence that people had agreed to their care and support plans. Staff we spoke with confirmed that people were involved in their care records.

One staff member said, "[Care record] reviews are recorded in people's words." However, from the records we saw there was no recorded evidence that people were present at regular reviews of these plans to ensure that they were up to date. This meant that robust recorded evidence could not be provided that people were actively involved in their care and support plan reviews.

Care records prompted staff to assist people to maintain their independence. Records recorded people skills and strengths as well as their assessed areas of risk. People were assisted by staff to maintain their life skills. One person told us how staff supported them with household chores, and how they had, "Done the shopping today with [care worker]."

The majority of people told us that staff respected their privacy and dignity by knocking on their door before entering their home or room. One person told us that staff asked their permission before they assisted. However, one person was clear that staff did not knock on their bedroom door before entering. Care records we looked at had clear prompts for staff to respect people's privacy and dignity at all times. Staff said that they tried to ensure that people they supported were encouraged to undertake as much personal care themselves as they could before offering assistance to help maintain people's dignity.

Advocacy was available for people if they needed to be supported with this type of service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Good

Is the service responsive?

Our findings

We saw people being supported by staff to pursue their interests and social activities. One person told us how staff supported them to go shopping. They said that, "I walk down the road, I go with staff." Care records we looked at documented peoples' interests which included games, puzzles and knitting. Another person told us how staff had supported them with various activities such as, "Having their nails done," and attending a dance.

Some people who used the service had employment or attended college courses. Other people were supported by staff to maintain their links with the local community by attending sailing classes, going swimming or maintaining friendships. Staff confirmed to us that they also supported people to attend their chosen religious ceremony as this was important to them. A support plan was in place called 'how I will stay in control' which documented meetings with the person's family member, social worker and care worker to review and update activities. This meant that people were supported by staff to maintain links with the community to encourage social inclusion.

Prior to using the service, people's care, and support needs were assessed, planned and evaluated to ensure that the service could meet their needs. Records showed that people's care records were reviewed on a regular basis. These reviews were carried out to ensure that people's current support and care needs were documented as guidance for staff that supported them.

From this an individualised plan of care and support was devised which provided guidance to staff on the care the person needed. Hospital passports in an easy read/ pictorial format were also available to accompany a person in response to an emergency admission to hospital. These documents gave the external health care service an individual summary of the person they would be treating. Staff we spoke with demonstrated to us a good understanding of each individual persons care and support needs. Care records we looked at showed that people's care and support needs, and personalised risk assessments were known, documented, and monitored by staff.

Care records we looked at were written in a personalised way about the individual. They held information for staff on what made people anxious, how staff were de-escalate and what individual assistance a person may require. Staff told us that they worked with the same people and that was because people needed routine and consistency to provide effective support and care to people. This was confirmed by care records we looked at.

People we spoke with told us that that they knew how to raise a concern. They told us that they would speak to staff if they were concerned about anything. One person told us that they would, "Talk to the office." A relative said, "If I needed to complain, I would contact the manager at Augusta." The relative talked us through an example of a concern they had and on raising the concern with service it had been resolved. We saw that the service's complaints policy was included in the service user guide. We asked staff what action they would take if they had a concern raised with them. Staff said that they knew the process for reporting concerns. One staff member said, "[They] would inform management." Records of compliments and complaints showed us that complaints were recorded and responded to appropriately and in a timely manner.

Good

Is the service well-led?

Our findings

The service had a registered manager in place who was supported by a team of care staff and non-care staff. During this inspection we saw that people were able to visit the office when they wanted to and were made welcome by staff. One person told us how they visited the office regularly and that they enjoyed this as staff, "Make [person] a drink." We saw that people who received a service and staff interacted well with the management who were observed speaking with people and staff and making them feel welcome during this visit. People we spoke with had positive comments to make about the staff. One person when asked if they could talk to staff and/or the management told us, "Staff are kind…I talk to the staff."

Staff told us that an 'open' culture existed and they were free to make suggestions, raise concerns, drive improvement and that the registered manager was supportive to them. Staff told us that the registered manager and management had an 'open door' policy which meant that staff could speak to them if they wished to do so. This made them feel supported. One staff member went on to tell us that, "I love it, the best job." Another staff member said that management were, "Always very supportive."

Records showed that people and their relatives were given opportunities to feedback on the quality of the service provided through surveys or meetings. Although one relative said that they were not aware of an opportunity to give feedback. Any improvements required then formed part of an action plan which detailed what action was to be taken, by whom, the timescale and date of completion.

Staff meetings happened and staff told us that they were able to raise any concerns or suggestions that they may have. One staff member gave us an example of a suggestion that had been made and how the management had listened to the suggestion and how an action had been put in place.

A system to regularly audit the quality of the service provided was in place. Any improvements required were recorded in an action plan to be worked on. Areas that formed part of the quality monitoring included, but were not limited to: support plans and risk assessments being followed by staff, and communication diaries. Also, incident and accident forms, food and fluid charts, body maps and medication were also reviewed. Records showed any actions taken as a result of these audits including the outcome and date action was completed. This meant that there was system in place to review the quality of the service provided to people living in the home.

The registered manager notified the CQC of incidents that occurred within the service that they were legally obliged to inform us about. This was done in a timely manner. This showed us that the registered manager had an understanding of their role and responsibilities.