

Instant Care Ltd

# Instant Care Rochdale

## Inspection report

Liberal Democrats  
144 Drake Street  
Rochdale  
OL16 1PS

Tel: 07473166111

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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 ●

# Summary of findings

## Overall summary

This inspection took place on 8 August 2018. This was the first inspection of Instant Care Rochdale since their registration with the Care Quality Commission in June 2017.

Instant care is a domiciliary care service located in Rochdale, Greater Manchester. The service provides personal care to people living in their own homes. At the time of the inspection the service provided care and support to two people. The service is waiting to submit a tender to join the local authorities approved provider list. If they are successful they expect to increase the number of people that they support.

We were assisted throughout the inspection by the registered manager. 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 registered manager at Instant Care had been registered since June 2017.

The training and induction records demonstrated that all staff had received safeguarding training. Staff told us what it was for and what action they would take if abuse was suspected or witnessed.

The service had risk assessments in place and managed risks safely. These included moving and handling assessments, environmental risk assessments, a household safety hazard checklist and health related risk assessments.

We looked at both care files in people's homes and observed that medication was managed safely. Staff were trained and people's needs were met in line with the support agreed in their care plan. We have made a recommendation about how the provider records and lists medications in the Medication Administration Records.

The service had robust recruitment procedures in place which helped to protect people against the risk of unsuitable staff. Appropriate checks were carried out before staff began working for the service.

At the time of the inspection the service was relatively small with two people using the service. Staff told us they had enough time to carry out their roles well. This was confirmed by the people who used the service. The service had not missed any visits in the previous year.

Infection control was covered in the induction and practice was checked through spot checks carried out by senior staff. This was well managed and staff understood their responsibilities and people using the service reported good practice in this area.

Both people that we visited confirmed that they were happy with the support from the provider and that their needs were being met as agreed in the assessment and recorded in the care plan.

Good support was in place for staff. This included a four-day induction, mandatory training and regular supervision. Staff told us that it was easy to access support from the registered manager.

Support with food and drink was identified in the initial assessment and was transferred into the support plan. The support plans we looked at contained sufficient information and guidance and the people we spoke to reported being happy with the support they received.

The service was responsive to people's health needs. People gave us examples of when the service had responded to their needs.

People we spoke with told us staff were kind, caring and reliable. We observed this during our inspection and found no evidence to the contrary. The service had a positive culture which was person centred and achieved good outcomes for people using the service.

People's independence was promoted and staff were very clear that it was their role to encourage people to do as much as possible for themselves before providing an intervention.

People were routinely involved in their care and were asked for regular feedback which was recorded. The feedback that we looked at was positive.

The service met the Accessible Information Standard. They routinely asked what people's communication needs and preferences were and these were clearly recorded in the people's files that we looked at.

Access to independent advocacy was promoted and information about how to contact these services were in the two files that we looked at in people's homes.

People's care plans were individualised and person centred. People were asked about their past histories and their likes and dislikes and a date had been set to review the care. We could see that the service had also been flexible and had changed care plans when requested to do so.

The service had received no complaints. There were good systems in place to manage complaints. This included a clear policy and templates to use to record complaints.

The service had internal quality assurance systems in place to monitor performance and to drive improvement. These included spot checks and audits.

## 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.

Staff understood their safeguarding responsibilities and felt able to report any concerns that they encountered.

Medication was administered safely.

Recruitment was carried out safely.

### Is the service effective?

Good ●

The service was effective.

Care plans were clear and met people's needs.

Good support was in place for staff.

The service was responsive to people's health needs.

### Is the service caring?

Good ●

The service was caring.

People we spoke with told us staff were kind, caring and reliable.

Independence was promoted and people were involved in their care and service sort regular feedback about their experiences.

### Is the service responsive?

Good ●

The service was responsive.

People's care plans were individualised and person centred.

The service had received no complaints. Feedback about the service was positive.

### Is the service well-led?

Good ●

The service was well led.

There was a positive culture which was person centred.

Staff received good support.

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# Instant Care Rochdale

## 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.

The inspection took place on 8 August 2018 and was announced. The provider was given 48 hours' notice of our intention to visit. This was because we needed to ensure there would be someone present at the office to facilitate the inspection.

The inspection was carried out by one adult social care inspector. The onsite visits gave us the opportunity to speak with the manager and office staff and review care records, policies and procedures.

Before our inspection the provider completed a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed the information we held about the service. This included any statutory notifications they had sent us. A statutory notification is information about important events, which the provider is required to send to us by law.

Before the inspection visit we contacted the local authority safeguarding and commissioning teams about the service to gather relevant information. We also contacted Healthwatch Rochdale. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We did not receive any negative feedback about the service.

During the inspection we spoke to the registered manager, all three staff members and we visited all the people using the service in their own homes.

During the office visit we looked at records relating to the management of the service. This included policies and procedures, incident and accident records, safeguarding records, complaint records, three staff

recruitment, training and supervision records, two care files, team meeting minutes, satisfaction surveys and a range of auditing tools and systems and other documents related to the management of the service.

# Is the service safe?

## Our findings

All the people using the service reported feeling safe. One person stated, "Yes 100%."

Policies and procedures for safeguarding people from harm were in place. Guidance was also provided in the staff handbook. The training and induction records demonstrated that all staff had received safeguarding training. These provided staff with sufficient guidance on identifying and responding to signs and allegations of abuse. We saw that safeguarding was discussed in staff supervisions and at team meetings. During the inspection we spoke with staff and asked them about their understanding of safeguarding. They were all able to tell us what it was for and what action they would take if abuse was suspected or witnessed. The registered manager had also attended training provided by the local council on provider safeguarding responsibilities and the service was signed up to the local council's newsletter and updates on safeguarding.

We looked at the whistleblowing procedure. It provided clear guidance for staff that needed to raise concerns. Whistleblowing was an agenda item in supervisions and all the staff we spoke to were comfortable raising concerns with the office and were confident that their concerns would be listened to and taken seriously.

We looked at how the service managed risk and reviewed both care files in the office and in people's homes. Each contained several risk assessments used to help keep people safe. These included a moving and handling assessment, an environment risk assessment, a household safety hazard checklist and a smoking risk assessment. Health related risks were covered in an assessment called, "All about me." Each risk assessment contained sufficient information to minimise any risks identified.

Risks to people and the service were managed so that people were protected. Systems were in place to record incidents, complaints and safeguarding. During the inspection it was agreed with the registered manager that a section would be added to include other notifications sent to the Care Quality Commission in future. The records were appropriate and included options to record further actions and outcomes. The three staff we spoke to also reported an open supportive culture in the service where they were encouraged to report any issues of concern. Given the small size of the service currently there had been no safeguarding, incidents, complaints or notifications recorded to date.

We looked at how the service managed people's medicines. The safe administration of medicines was covered in the induction and staff had to be assessed as competent before they could carry out this aspect of the role. We checked all three staff files and all had completed this in their induction. We looked at both care files in people's homes and observed that medication was managed safely. There were no gaps in the Medication Administration Records (MARs) sheets and there was clear agreement and documentation about who and when the medication would be administered.

We recommend that the service considers current guidance provided by the National Institute for Clinical Excellence on where they document the types of medication people take. The care files did record this



information but it was not kept with the MARs record. The MARS record needs to be a clear record of all medicines administered or applied. Where medicines are recorded as 'dosette' or blister pack there should also be an accurate record of the medicines contained in the blister pack that is kept with the administration record. The registered manager agreed to review this and we will check this at our next inspection.

We looked at seven records of staff spot checks and each included a section on medication to check staff performance in this area and a section for further action if required. No concerns were recorded. This was supported by a more detailed medication assessment of competence which was carried out with all staff and listed 19 different areas to audit. We saw that one staff member started in January and had received two medication audits in February and two in May.

The service had robust recruitment procedures in place which helped to protect people against the risk of unsuitable staff. We looked at three staff personnel files to check that the procedure had been followed. Appropriate checks were carried out before staff began working for the service. Each file contained application forms, photos and proof of identification, evidence that at least two references had been sought from previous employers and Disclosure and Barring Service (DBS) checks had been carried out. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This demonstrated that staff had been recruited safely and the policies and procedures had been followed.

We spoke with three staff and they told us that they felt there was enough staff employed to meet people's needs and keep people safe. Staff absences were covered by senior staff if other staff were not available. The service had not missed any visits. The registered manager explained that they would recruit more staff if they were accepted on to the councils approved provider list and would introduce new technology to monitor visits and staffing levels.

We saw infection control policies and procedures were in place and had been updated in April 2018. Infection control training was an essential part of the induction programme for all staff. Regular infection control audits were undertaken through staff spot checks and quality assurance checks with people who used the service. All staff when asked could describe what their responsibilities were in relation to infection control and we observed that protective clothing was used prior to people receiving personal care in the homes that we visited and the two people we spoke to confirmed that this was always the case.

# Is the service effective?

## Our findings

People supported by the service had received an assessment of their needs before carers commenced their visits. This ensured the service had information about the support needs of people and they could confirm these could be met. Following the assessment, the service, in consultation with the person had produced a support plan for staff to follow in both files that we looked at.

Care plans were kept in people's homes and a copy held in the office. The care plans we looked at identified each person's individual needs and gave clear information about the support people needed and the tasks staff were to complete at each visit. Clear notes about the support provided were made after each visit and a task list to tick when completed.

Both people that we visited confirmed that they were happy with the support that they received and that their needs were being met as agreed in the assessment. One commented, "I find the care staff reliable, relaxed and friendly. I can discuss things with them if I need to." A relative had called the service in June and stated, "[Name] rang the office complimenting [Name]. He said that she is doing a really good job with [Name] and is really happy with the care his mum is receiving. He also mentioned that his mum loves [Name] to bits and looks forward to seeing her every day."

There was good support in place for staff. We looked at three staff training records. Each was well documented and provided evidence that induction and probation had been completed and listed all the training with dates and certificates for each. An induction checklist was signed by all staff. The induction included Equality and diversity, privacy and dignity, Health and safety, moving and handling, basic life support, fluids and nutrition, safeguarding adults and children, infection control and mental health awareness. There was also a detailed employee staff handbook that was signed by all staff. The staff completed additional training in first aid, food hygiene, medication, fire safety and were enrolled on the care certificate.

Formal supervision was provided four times a year. Supervision provided managers with the opportunity to evaluate the performance of staff. We looked at a sample of three staff supervision records. The agenda was detailed and included health and safety, safeguarding, whistleblowing, concerns or worries, personal development, timekeeping, standard of working and a good section for each subject area to record praise for staff and/or areas for improvement.

The records that we saw showed that supervision was regular and took place every three months and all staff reported that they received good support. One commented, "Yes 100%. Our manager is very good. She is easy to talk to. If I feel I need more help she will go through things with me." A second stated, "Yes we always receive good support from the manager. She always listens and she always does her best."

We looked at how the service supported people to maintain a balanced diet. Support with food and drink was identified in the initial assessment and was transferred into the support plan. The support plans we looked at contained sufficient information and guidance. The eating and drinking section provided the

option to record any concerns about nutrition and hydration and action to take to manage this. There was a section on likes and dislikes and a weekly planner that was completed with the person detailing what food and drink they had each day. There was an additional section to record any religious, cultural or lifestyle requirements in relation to food and drink.

Both care files demonstrated that the service was responsive to people's health needs and had examples where they had done so. On one occasion staff had noticed that someone's eye was infected and promptly agreed to call the GP and family. Both people using the service agreed when asked that the service was responsive to their health needs.

The registered manager told us that they would routinely support people with their medical appointments if needed or requested to do so if agreed through the initial assessment or at later stage if required. This has not been requested yet. If they arrived and a person was unwell or had had an accident, such as a fall, they would report this to the office who would inform the person's family. If required the staff would contact the person's GP or 999 and stay with the person until the ambulance or their family arrived.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 people lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The service had a clear policy in place that provided guidance for staff to follow. The service does not currently have anyone using the service who has been assessed as lacking capacity in any area of their lives. The service will not take anyone who has been assessed as lacking capacity until the staff training has been completed next month. We will check this when we next inspect the service.

We saw in the care files that people agreed to their care and support and signed to say that they agreed. The people we spoke with told us that before receiving any care, staff always asked them for their consent.

## Is the service caring?

### Our findings

People we spoke with told us staff were kind, caring and reliable. Staff spoke about people with genuine empathy and demonstrated a commitment to ensure they received good care. We observed this approach during our visits to people's homes. Staff commented, "I see the same two people and know them well. I know their care needs 100%. I know what they like and don't like."

The registered manager and staff worked to ensure people were involved in planning their care and support. The support provided was person centred and was based on their needs. This was checked routinely every three months using a quality assurance assessment where people were asked for their views about their care and support. All the paperwork recording this were positive.

Where the person consented relatives were also invited to annual reviews to contribute to care planning and we could see that these dates had already been arranged.

Staff told us they took people's wishes and needs into account and offered them as much choice and variety as possible. People felt they were treated with dignity and respect and staff could explain how they would always seek guidance from the person before proceeding with personal care. Staff members that we spoke to stated that they would be happy for their own family to use the service.

Independence was promoted and staff were very clear that it was their role to encourage people to do as much as possible for themselves before providing an intervention. Both people that we visited confirmed this was the case and that staff had the time to carry out their roles well.

The service met the Accessible Information Standard. They routinely asked what people's communication needs and preferences were and these were clearly recorded in the people's files that we looked at. The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and social care services. Section 250 of the Health and Social Care Act 2012 states that all organisations that provide NHS care or adult social care must follow the standard.

There was clear collaboration between the service and people they supported. For example, people's preferences and information about their backgrounds had been recorded. Additionally, the service had carefully considered people's human rights and support to maintain their individuality. This included a charter of rights in the service user guide.

Equality and diversity information in the care files needed to be revised to ensure that people were given the opportunity to share relevant information if they chose to in line with the Equality Act 2010. The legislation identifies nine protected characteristics such as religion and sexuality that people should be given the option to share and discuss. This is important as it can help to inform care planning and to remove barriers to good care. We will check this when we next inspect.

Access to independent advocacy was promoted and information about how to contact these services were in the two files that we looked at in people's homes. Independent advocacy services can support people to participate in meetings about their care and support and can help people to secure their rights.

We saw all records were held securely and the induction covered confidentiality and data protection. This helped keep people's care and support private where required.

## Is the service responsive?

### Our findings

We asked both people who used the service if the service was kind and caring. Both answered, "yes" and were happy with the support they received. One stated, "They make things easy. They are good at communicating and are easy to contact." The other person stated that the best thing about the service was their reliability.

The service was focused on providing high quality care to the individual using the service. The service user guide contained useful information about what the service provided, information on how to complain and how to access independent advocacy. It also included a charter of rights that listed 10 rights which included the right to make informed choices and to take positive risks. It highlighted the importance of the relationship with the carer and the right to change carer if required. The statement of purpose also included a personal testimony from the registered manager about their own lived experience where they support a family member with special needs and how this experience motivates them to provide excellent care to others.

People's care plans were individualised and person centred. People, their relatives and other representatives were fully consulted and involved in the decision-making process before the service started. People were asked how they would like to be addressed and asked if there was any further information that they would like to share or if there was anyone else they wanted to involve in the assessment. The care plan also included a section on communication to ensure that any relevant issues were picked up and that they knew what the person's communication preferences were.

The care file contained a service user profile where people were asked about their life history including previous work history, their hobbies, family background and cultural and religious beliefs. The all about me assessment recorded people's needs and how they would be met. This included information about medical conditions, personal care and physical wellbeing, mobility, health, mental health and food and drink.

We looked at systems for managing complaints. Good documentation was in place and the complaints procedure was discussed with people during the face to face meeting to agree the initial support plan. Complaints were also promoted in the service user guide that was given to each person using the service. The two people we visited at home knew how to call the office and would ask for family support if they ever needed to complain.

The service had a complaints policy in place which included timescales for responding to complaints received and details of who people could complain to if they were not satisfied with the response from the service. The registered manager told us the service had not received any complaints and we found no evidence to contradict this.

The service had a clear and up to date policy on end of life. At the time of the inspection the service had no people on end of life currently. The policy detailed how end of life care plans would be developed with the person as they neared the end of their life and would include a discussion about their wishes in relation to

family involvement, comfort and pain management, nutrition, cultural or religious needs and good supervision and support for staff affected by their involvement.

## Is the service well-led?

### Our findings

There was a registered manager in post who had been registered since June 2017. 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 service had a clear vision detailed in their statement of purpose and clear strategy to provide high quality care and support. We observed a positive culture which was person centred and achieved good outcomes for people using the service. The records we looked at and the people we spoke to demonstrated that this was the case.

The registered manager kept up to date with best practice and changes to legislation through the local council and signing up to updates from the Care Quality Commission, Social Care Institute for Excellence, National Institute for Clinical Excellence and accessed best practice guidance through Skills for Care.

Policies and procedures were available and up to date. There were good communication systems in place. These included up to date care files, regular team meetings and staff were well trained and were clear about their roles and could describe in detail the support they provided.

Staff received good support and could respond to people's needs as they arose. They reported an open culture where they could call or go to the office if they needed support. They did not have to wait for supervision or team meeting. Regular team meetings were held and staff contributed to the agenda. We looked at the minutes from the meetings from February to July 2018 and saw that there were clear agenda items that included reminders and updates for staff.

This was further supported by staff satisfaction surveys that took place every three months where they were asked seventeen different questions related to their job role and job satisfaction. All the surveys we looked at were positive.

The staff felt part of a supportive team and told us managers were approachable and listened to them. Staff told us the service was well-led, open and honest. One staff member told us, "Yes. The manager is very supportive. If I get stuck I will call and she will offer guidance. Procedures and guidelines are easy to follow." A second staff member commented, "Yes I am very happy. If I ask for help they always give good advice."

The service had internal quality assurance systems in place to monitor performance and to drive improvement. This included regular spot checks where staff were observed in practice and quality audits carried out in person with the people who used the service every three months.

During the inspection we found the service was managed by professionals who were clearly committed to the people they support and the staff that worked with them.



