Mrs Pauline Ann Daniels

AA-I-Care - 35 Southwell

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

Summary of findings

Overall summary

The inspection site visit took place on 1 November and 2 November 2018 and was announced.

AA-I-Care – 35 Southwell is a domiciliary care agency. It provides personal care to people living in their own homes in the community. Not everyone using the service receives a regulated activity; the CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

At the time of the inspection the service was providing personal care to 23 people living in their own homes.

People were protected from avoidable harm as staff received training and understood how to recognise signs of abuse and who to report this to if abuse was suspected.

Staffing levels were sufficient to provide safe care, and recruitment checks had ensured they were suitable to work with vulnerable adults.

When people were at risk staff had access to risk assessments and understood the actions needed to minimise avoidable harm.

The service was responsive when things went wrong, they were open and reviewed practices and had a robust system in place to manage incidents.

Medicines were administered and managed safely by trained and competent staff. The quality assurance and management lead carried out monthly audits of Medicine Administration Records (MAR).

People and their relatives had been involved in assessments of care needs and had their choices and wishes respected including access to healthcare when required. The service worked well with professionals such as nurses, occupational therapists and social workers.

People were supported to have maximum choice and control of their lives and the policies and systems in the service together with staff understanding supported this practice.

The registered person and the quality assurance and management lead, actively sought to work in partnership with other organisations to improve and nurture positive outcomes for people using the service.

Care and support was provided by staff who had received an induction and on-going training that enabled them to carry out their role effectively. Staff felt supported by the registered person and quality assurance and management lead.

People, their relatives and professionals described the staff as caring and caring. People could express their views about their care and felt in control of their day to day lives.
People had their dignity, privacy and independence respected and staff understood their responsibilities in relation to this.

People had their care needs met by staff who were knowledgeable about how their individual preferences.

The service had an effective complaints process and people were aware of it and knew how to make a complaint. People and their relatives told us they felt confident their concerns would be addressed. The service actively encouraged feedback from people.

Relatives and professionals had confidence in the service. The service had an open and positive culture. Leadership was visible in the service and promoted inclusion. Staff spoke positively about the management team and felt supported by them.

There were quality assurance and auditing processes in place and they contributed to service improvements. Action plans were carried out and those responsible kept things up to date.

The service understood their legal responsibilities for reporting and sharing information with other services.

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 remains good.	**Good**
Is the service effective? The service has improved to good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

AA-I-Care - 35 Southwell

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 site visit took place on 1 November and continued on 2 November 2018 and was announced. The provider was given 48 hours' notice. This was so we could be sure a manager or senior person was available when we visited. The inspection was carried out by one inspector and an expert who telephoned people to gather their views of the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had experience in dementia care and care at home services.

Before the inspection we reviewed all the information we held about the service. This included notifications they had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with eight people who used the service, three in their own homes and five on the telephone. We spoke to seven relatives, two health and social care professionals and three care staff.

We spoke with the provider, quality assurance and management lead and a care team manager. We reviewed six people's care files, eight medicine administration records, policies, risk assessments, health and safety records, consent to care and quality audits. We looked at three staff files, the recruitment process, complaints, training and supervision records.

Good

Is the service safe?

Our findings

People told us they felt safe with the service they received from AA-I-Care – 35 Southwell. The service had risk assessments, policies, procedures, quality checks and support systems in place. A person told us they were happy with the staff and said, "I feel safe with them". A relative told us, "They [staff] are very caring with them and make them feel safe". The service had an out of hours on call system, this was shared amongst senior staff with management support on a rota basis. On call staff told us confidently the steps they would take to keep people and staff safe in an emergency. An example was shared where staff could not gain access to a person in their home, steps were taken to make sure that person was safe. This included contacting neighbours, families and hospitals.

People received their medicines safely. All staff were responsible for the administration of medicines, they had all received training and had had their competency assessed. The service had Medicine Administration Records (MAR) which were checked against the persons medicines. Any changes to a person's medicine were reported to the quality assurance and management lead and the MAR was amended. The service had a process of checking the MAR had been completed correctly each day and any discrepancies were reported by staff. Audits in relation to medicines and there were completed and actions carried out from each one. The MAR contained special instructions such as where on the body prescribed creams should be applied. Where people were prescribed medicines that they only needed to take occasionally, guidance was in place for staff to follow to ensure those medicines were administered in a consistent way.

There were enough staff working to provide safe care for people. The provider was responsible for scheduling staff to the visits. The quality assurance and management lead told us they had not missed any visits since the last inspection. The service had an electronic monitoring system in place which alerted the management team if visits were late. Staff used their phone to scan into the system when arriving at a person's home and then again once the care visit was completed. This was monitored by the quality assurance and management lead and they told us, "Sometimes we need to reassign visits if someone is running late as it may be impossible for them to catch up".

People received a schedule of visits for the upcoming week, these were seen during our home visits. A person told us, "I get a rota weekly", and another said, "They always come on time and I get a weekly rota". A relative told us, "There are enough staff and they cover all the shifts we need. We are very pleased, they are usually on time and they stay the full time allocated for my loved one". Staff told us they had enough time to travel between their visits. The registered person told us, "We work out the travel time by the distance between our clients so it differs". A person told us, "They let me know if they are going to be late by telephone. Sometimes it's just a traffic delay or the person before me takes a bit longer".

The service had a suitable recruitment procedure. Recruitment checks were in place and demonstrated that staff employed had satisfactory skills and knowledge needed to care for people. All staff files contained appropriate checks, such as references and a Disclosure and Barring Service (DBS) check. The DBS checks people's criminal record history and their suitability to work with vulnerable people.

Staff were clear on their responsibilities with regards to infection prevention and control and this contributed to keeping people safe. The service provided staff with gloves and aprons and we observed staff using these while providing care to people. The service carried out unannounced spot checks of their staff and records confirmed that gloves and aprons were worn when necessary.

The service had effective arrangements in place for reviewing safeguarding incidents. Staff demonstrated knowledge of signs and symptoms of abuse and who they would report concerns to both internally and externally. The quality assurance and management lead had recently attended 'Safeguarding for Managers' training. Safeguarding information and guidance together with contact numbers were displayed in the office. A relative told us, "There have not been any safeguarding issues but I feel confident they would let me know if there were any". A professional told us, "The service has fully co-operated with safeguarding meetings, providing documents when required".

The service had a robust system for the management of accidents and incidents. Staff understood their responsibilities to raise concerns, record accidents, incidents and near misses. An accident and incident tracker was used by the service. The tracker system allowed managers and staff to record details of the accident or incident, actions taken, people involved and findings. Details of where the evidence and records could be found were included. The quality assurance and management lead told us, "We monitor the tracker and look for trends, we communicate this to the staff by message or meetings". There were many examples of these records including where learning had been communicated to staff. An example was good practice improvements such as reminding staff about hand hygiene and wearing their gloves.

Risk assessments were in place for each person for all aspects of their care and support. Moving and handling assessments completed by occupational therapists were in files where they were required. We observed staff using equipment to transfer a person and their assessment was followed. A person told us, "The are all very good at doing my transfers, I feel safe". Risk assessments were reviewed routinely every six months or sooner if things changed. For example, risk assessments had been updated in response to a change in a person's condition and general health. Copies of the risk assessments were kept in the person's home so staff could refer to and follow them to ensure they were working in a safe way. Staff told us details of people's individual risks during our conversations with them. The quality assurance and management lead told us, "I want our clients to live their lives as safely as possible".

All equipment that staff used during their visit had a visual check to ensure its safety. Equipment used to support transfers required annual maintenance and a record of these checks was included in the environmental risk assessment. People's care and support plans held information which told staff how to support people in the event of an emergency, such as a fire in a person's home. The care plans contained details of how the person should be supported to move and the exits to use. Staff were instructed in the plan to call for the emergency services and advise the call handler of the persons condition or mobility difficulties. All staff had received health and safety training, which included fire safety.

Good

Is the service effective?

Our findings

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 they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At our last inspection we found that the service was not consistently meeting the requirements of the MCA. We made a recommendation they seek guidance to improve their recording and staff awareness of the MCA. At this inspection we found improvements had been made.

Assessments had been carried out for people to determine their capacity to make certain decisions. The provider told us they routinely seek guidance from the local authority mental capacity team. People's care and support plans contained information about their mental capacity. The service was reviewing their documentation for the assessment and planning for those who lacked capacity, to ensure people's rights continued to be protected. We heard the provider contacting the mental capacity team about a person and discussing capacity issues within the team.

Staff had received MCA training and were able to tell us the key principles and how this was applied in their daily work with people. Staff records showed training had been completed. A staff member told us, "Mental capacity is assessed around specific decisions". A professional told us that they had worked well with the service with a complex situation and said, "Communication was brilliant and they attended best interest decision meetings".

People had consented to their care. There were signed consent forms in each file. by being involved in agreeing their individual care plans. People had signed their consent forms and care plans and a copy was in their file in their home. A staff member told us, "I always ask for consent". We observed staff asking and receiving peoples consent to provide care. They explained throughout what they were going to do for the person before they did it. Gaining consent was included in the regular spot check of staff and records showed staff asked peoples consent.

The service had a detailed induction for all new staff to follow which included shadow shifts and practical competency checks in line with the care certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. The service used both online and face to face training for their staff and completed competency assessments in the community. The quality assurance and management lead told us that staff received question workbooks throughout the year and they had a different focus each month. A staff member told us, "I have done food safety and moving and handling recently". Staff felt supported to carry out their role effectively, and many had been supported to undertake health and social care diplomas. The service had created a peer review system which allowed staff to observe and comment on each other's practice. Staff who had been part of this said it was useful. A staff member told us they felt it was good to be able to progress in their career and said, "They [provider] have helped me to feel confident in what I do. To have the opportunity to do it has been really good".

Staff told us they had regular supervision and appraisals, they felt these were positive experiences. The service completed support logs in between formal supervisions. Support logs were used to manage performance and record any guidance, training or support given to or requested by staff. A review of the support logs took place within the formal supervision. Supervision records showed a review of actions from the previous session, reflection and action planning for the future. A staff member told us, "I feel comfortable to say anything in my supervision". Another staff member told us, "I feel I can speak openly, I feel really supported here".

People's needs and choices were assessed and care and support was provided to achieve effective outcomes. Peoples care and support plans showed people's food and drink preferences. Many people were supported by staff to eat and drink within their visits and records were detailed. During our home visits we saw a person who was reluctant to drink and was prone to urinary infections. We observed a staff member encouraging the person to drink by sitting with them. The staff member had a drink too and had a general conversation with the person with the occasional verbal prompt to drink. This was clearly a positive experience for the person as they were smiling throughout and enjoying their drink. The member of staff told us how important it was for the person to drink and said without the prompt they would forget. Records showed that food and drinks were detailed by the staff throughout.

People were supported to receive health care services when they needed them. All records seen showed medical or specialist input. Care plans and records showed that instructions from professionals were being followed correctly. We observed a member of staff having a conversation with a person and their relative regarding a medical issue which was being monitored. The member of staff made the necessary record in the daily notes. Staff told us they had good relationships with medical professionals, and were confident to request visits for people when needed. An example of this is was a member of staff spoke with the district nursing team to meet up so a person could receive catheter care. The member of staff said it worked well and they could support with transfers so the nurse could attend to the person's catheter. The person told us they were happy to receive medical input promptly and said, "I am very lucky". A professional told us, "Once we give instructions, they carry it out".

Good

Is the service caring?

Our findings

People, professionals and their relatives told us staff were kind and caring. Some of the comments we received about staff were: "My carer is top notch", "I couldn't do without them", "They [staff] are very kind and spend a lot of time talking about sport", "They are generally kind and know what is important to me", "They are everything to me. I couldn't be without them". Relatives told us, "They are all very attentive and always ask me if I am ok as well", "They are just so good, amazing. Really lovely". A professional told us, "They are always professional and willing to go that extra bit. They are really helpful".

People told us that they saw regular staff and this supported continuity of care, because staff that attended their visits understood their needs and preferences. The provider and the quality assurance and management lead told us that they try to match skills and interests when arranging the visits. They said, "We are a small company and we can build area's and we can be flexible. It helps us to build relationships". Visit times meet people's preferences and regular staff attend them. A staff member told us, "I have my regular clients". People's printed schedules showed regular staff were attending their visits. A relative told us, "It's nice to have just two regular carers so my loved one gets used to them". A person told us, "They know me well, it's good to have regular carers".

People's cultural and religious needs were considered as part of the assessment process. Staff received training in equality and diversity. Staff told us they would happily provide care for anyone regardless of their background.

People told us they were happy with the care they received from AA-I-Care. Comments we received included: "If I didn't have my carers to help I would go downhill quickly", "They are very good, I am glad to see them", "The care provided is great and fantastic". A professional told us, "My client is happy with the care, they trust the staff. They always go over and beyond for them".

Staff were aware of their responsibilities with regards to confidentiality. Staff knew they had a legal duty to maintain confidentiality and to protect personal information they may encounter during their work. We observed staff protecting information of people during our home visits by recording details of the care they gave by making a record and ensuring that information was returned to the agreed place.

People were encouraged to be independent and individuality respected. The quality assurance and management lead told us, "We are the voice for our clients. I am passionate about keeping people at home and where they want to be". A staff member told us, "People should still have their own life. You have to work with them to achieve a good outcome and that's independence".

People were treated with dignity and respect. We observed respectful interactions during our home visits. An example of this was a member of staff supporting a person with their personal care. The member of staff spoke to the person throughout, offering choices and reassurance. The staff member praised the person and offered encouragement. The person told us afterwards they were very happy with the staff member. A relative told us, "They absolutely treat my loved one with dignity and respect".

People were encouraged to make decisions about their care. People were involved in their care, records showed input from the person, their family and professionals. There was a system for review every six months or as things changed and people were involved in that. A relative told us, "The care plan is reviewed and if I am here I will be involved in that".

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans were in place and regularly reviewed. We observed information and updates regarding people's care being communicated by staff in person and by telephone to the quality assurance and management lead during the inspection. The service received a request to increase visits to a person following their discharge from hospital. This was discussed with the provider then staff were allocated to the visits. This meant the service was responsive, and the person could return home straight away.

People told us they received responsive care. A person told us, "If I need to change visits around, it's never a problem". Another person told us, "They call me if someone is running late and let me know". A relative told us, "They react really well when my loved one needs them to". A professional told us, "AA-I-Care are very responsive. It is important to us that they respond so well. They were able to provide care to a person with very short notice. It worked well". Another professional told us, "We made a mistake and they told us straight away, they were brilliant".

People told us they had been involved in discussions about their needs and wishes and had contributed to the creation and review of their care plans. Care and support plans were personalised and people were involved in designing how and when their care would be provided. A relative told us, "The care plan is reviewed and if I am here I will be involved in that". Peoples care plans had detailed life and medical histories. Plans contained information and details specific to their medical conditions such as, dementia, multiple sclerosis and conditions affecting mobility.

Creating and maintaining links with the community was important for the service. They had various charitable links to the community. The provider told us they sponsored floral arrangements in the town and were recently involved in the local summer fair. People who use the service and their families from the local area were also invited to events to help to integrate people into their community.

People knew how to make a complaint and the service had a clear procedure in place. The service dealt with minor concerns as 'grumbles'. The quality assurance and management lead told us, "If we deal with the grumbles right then they do not turn into complaints". Records showed that grumbles and complaints were dealt with within agreed timescales and actions had been carried out to people's satisfaction. Information on how to make a complaint was included in the information file in the persons home. People told us, "Yes we would know how to complain". Another person said, "I have never made a complaint but if I did I would tell them straight". A relative told us, "I have made a complaint and it was resolved". A professional said, "They will listen, the managers will come out and address issues".

The service met the requirements of the Accessible Information Standard. The Accessible Information Standard (AIS) is a law which requires services to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The service had considered ways to make sure people had access to the information they needed in a way they could understand it, to comply with AIS. People's assessments made reference to their communication needs and explained how

people wished to communicate. We were advised of a person's communication difficulties during our home visits. The staff member told us a person was living with a hearing impairment and that we would need to speak into their left ear. We would need to speak in a clear, loud tone. Following this guidance, we could communicate well with this person.

At the time of the inspection the service was not providing end of life care for anyone. The provider told us that they do provide end of life care and work together with palliative care teams. The registered person told us they work with palliative care nurses and they take the lead with end of life support to people in their own homes. The service had received compliments from families about their care and support of those at the end of their life. We read: 'Thank you for all the love and kindness', 'Thank you for the professionalism, care, love and humour for our loved one', 'Extremely happy with the carers and support', 'Thanks to all the carers for attending the funeral".

Good

Is the service well-led?

Our findings

Quality assurance systems were in place to monitor the standards of care provided at the service. Various audits took place and the quality assurance and management lead had created a spreadsheet to track those audits and the actions from them. An example from the audit of daily records was that it was identified that there was a lack of detail about choices offered and where independence was promoted. In this case the quality assurance and management lead had addressed this with the individual staff and it was discussed in their supervision.

There was a plan for developing the service. The provider and the quality assurance and management lead were planning for the future through meetings and discussions. They told us they included people and staff in those discussions. The provider told us, "We never advertise our services we rely on word of mouth. The quality assurance and management lead told us, "We have a real culture here and are passionate about our team". People, families and professionals we work with recommend us". They also told us, "We want to look after our staff and we fight for our clients, we are very good at challenging things". Staff told us they felt happy working for the service by saying, "It's not just a job, it's my career", another said, "It's a small company and family orientated".

The provider and quality assurance and management lead had created an open working environment and could be contacted in person or by telephone. Staff were seen coming and going at the office throughout the two days of our inspection. There was a jolly, relaxed atmosphere, staff were welcomed. Staff told us they felt supported by the management staff. Some of the comments from staff were: "I can speak to the management team [names] anytime", "I feel appreciated by the office team", "Management tells me I am doing a good job, I feel appreciated here", "They are very good and take concerns seriously". Professionals told us they had good relationships with the management team.

The service sought people's feedback and involvement. We saw the results from the March 2018 questionnaire. The survey asked various questions and responses were very positive. 100% of people felt the staff treated them with dignity and respect. Other responses showed that on average of 90% of people were mostly or always happy with their care service. There was an action plan in place. An example was that a slight improvement was needed to complaint handling. The service created a call log which we observed the completion of throughout the two days. They also offered training to staff on dealing with phone calls, this was monitored by the management team.

The provider and quality assurance and management lead kept their skills updated by attending training within the service and externally. They had attended regular local authority provider forums, homecare provider meetings, learning hubs and they subscribed to online guidance and publications.

The provider understood their requirements under duty of candour that is, their duty to be honest, open and transparent. A professional told us, "They will hold their hands up if things go wrong".

Systems were in place for learning and reflection. The quality assurance and management lead told us that

the incidents and accidents were discussed with the provider and the senior team. Actions taken, lessons learned and practice improved. Records showed many examples of learning from incidents including improvements which included hand hygiene, delayed visits and changes to equipment for people. Learning was discussed with staff during meetings or by messages. The service produced a staff newsletter which detailed improvements and lessons learned. It gave staff guidance, training news and reminders such as making sure they and people had plenty to drink during the hot weather. The newsletter contained updates on their colleagues such as new starters to promote team working. The quality assurance and management lead told us, "Staff told us they would like to be told any updates so I produced the newsletter to keep them informed".

The service had good working relationships with people, families and professionals. A person told us, "I can chat to the manager and I see them regularly". A relative said, "The manager came out from the care agency a few weeks ago and asked if I need extra help". Another relative told us, "The manager runs it quite well". A professional told us, "AA-I-Care works well with us, and various specialist support teams". Another said, "They are really good at joint working, we have no problems".