

Affection Care Services Ltd

Affection Care Services Ltd (Bucks)

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Affection Care Services Ltd (Bucks) is a domiciliary care service providing personal care to people in their own homes. The service was registered with the commission in October 2018, this is its first inspection. At the time of the inspection 18 people were using the service.

People's experience of using this service and what we found

This service was registered with us on 22 October 2018 and this is the first inspection. People told us they felt safe with the care the service provided.

We found the recording of the administration of medicines did not always reflect medicines had been administered in a safe way. There were no risk assessments in place for medicines and there were no "as required" (PRN) protocols in place to advise staff on when to give some medicines. The provider had a plan in place to increase the training for staff in this area, but this had not taken place at the time of our visit.

Care plans were in place for people, however some risks assessments were not in place. For example risk assessments related to people's health needs.

Staff understood how to protect people from abuse, however, the senior staff required further training in responding to allegations of abuse. This training was being sourced at the time of our visit. The information provided to staff about how to report safeguarding was not up to date or accurate. The registered manager told us they would amend this immediately.

We found sufficient checks had been carried out to minimise the risk of employing unsafe staff. There were sufficient numbers of staff to support people and care for them safely. Staff received training and support to enable them to carry out their role.

People described staff as "Super", "Friendly and competent". "Very helpful" and "Very Caring". They felt comfortable raising concerns and providing feedback to the provider. People were supported with eating and drinking if this was an identified need. Where people's health needs required external professional interventions, people were supported to receive this, and any recommendations were followed through by staff. They worked with external agencies to ensure care was consistent, appropriate, and safe.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The service aimed to provide person centred care, records reflected how people's individual needs had been assessed and a care plan was then devised to meet their needs. Staff were seen to go beyond expectations when they supported a person to enjoy an outing into the community. Where possible staff spent time with

people discussing topics of interest.

The service was not providing end of life care but planned to do so in the future once training for staff had been undertaken. The registered manager worked hard to establish the service and was open and receptive to feedback and new ideas. They were clear of their aim to provide the best care they could to people.

People spoke positively about the management. They felt there was an open and honest culture and when issues arose these were responded to quickly and effectively. The registered manager was aware of their responsibilities under the duty of candour. They had quality assurance audits in place, but these needed to be developed to give a more detailed overview of the service, including medicines, risk assessments and records. The registered manager had been planning to address some of these areas before our visit.

You can see what action we have asked the provider to take at the end of this full report.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Why we inspected

We carried out this inspection as part of our inspection programme.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was effective.

Details are in our effective findings below.

Good ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Affection Care Services Ltd (Bucks)

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

The inspection was carried out by an inspector.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 28 October 2019 and ended on 29 October 2019. We visited the office location on 28 and 29 October 2019. We spoke to people their relatives and staff on the telephone on 4 and 5 November 2019

What we did before the inspection

Prior to the inspection we reviewed the information we held about the service, this included notifications we had received from the provider. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about.

The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

In this service the provider is also registered as the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

During the inspection

During our visit we spoke with the owner who was also the registered manager of the service, the office manager, and a consultant trainer. Following our visit to the office we spoke with two care staff members on the telephone. We also spoke with one person and the relatives of three people who used the service. We reviewed various records of care including three people's care plans. We also examined documents related to medicines, namely medicine administration records, (MAR) charts. We reviewed records related to service audits, the employment and support of staff and the operation of the service.

After the inspection

We continued to seek clarification from the provider to validate evidence found regarding the management of staff.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated as requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely; Assessing risk, safety monitoring and management

- Records did not demonstrate medicines had been safely administered. We examined medication administration records (MAR). One person's records did not provide enough information to assure us the medicines had been administered in line with the prescription. There were no signatures or explanations given as to why a medicine had not been administered for three and a half days. This was an important medicine as it is used to help prevent strokes or blood clots.
- We checked the daily records of care. One record stated the medicines had been administered on one occasion over the three days, but this was not recorded on the MAR chart.
- Another person's records demonstrated they had not had cream applied. There was no explanation on the MAR chart why this had happened.
- There were no PRN (no pro re nata) or "when required" medicine protocols in place. These are necessary to inform staff of how and when this medicine should be administered, for example pain relief. There were no risk assessments in place for medicines. This meant staff would not necessarily know the signs of under or overdose or side effects. We discussed our findings with the registered manager. They told us they would take immediate action to remedy the areas of concern.
- Risk assessments related to the care being provided had been completed. For example, moving and handling risk assessments were in place for people. However, risk assessments were not in place for people's health conditions. This was important, as without this, unidentified risks placed people in possible danger. We discussed this with the registered manager who told us they would ensure this was addressed as soon as possible.
- We found records such as the safeguarding policy needed amending. Some care records needed reviewing to ensure risk assessments were in place, for example, one person was allergic to fish and eggs. The records stated the person developed a rash if they consumed either foods. However, there was no guidance for staff on how to minimise the risk or the action to take if a severe allergic reaction took place.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Medicines were administered by trained staff. The service had employed a training consultant to provide training and complete quality assurance checks including areas such as spot checks on staff and to seek feedback from people. They told us they were going to complete training to enable them to carry out further medicine training with staff. Staff currently had their competency assessed by the registered manager once training had been undertaken, and before they could be left to administer medicines independently.

Systems and processes to safeguard people from the risk of abuse

- People's relatives told us they believed they were receiving a safe service. Staff received training and understood how to identify indicators of abuse. They were aware of how to report concerns. The service had a safeguarding policy in place, however, the information in the policy was not correct, for example the telephone numbers for the safeguarding team were incorrect. The registered manager agreed to review the document and make the necessary changes.
- When we discussed hypothetical safeguarding situations with the registered manager, it was clear they had a basic understanding of the correct process to follow once a disclosure had been made. We discussed with the registered manager the benefits of completing training in responding to allegations of abuse. They immediately started to source the appropriate training. Where concerns had been raised the registered manager had taken appropriate action.

Staffing and recruitment

- We reviewed the content of three staff members recruitment files. We found sufficient checks had been carried out to minimise the risk of employing unsafe staff. References had been obtained from previous employers, Disclosure and Barring Service checks had been completed to check for candidates who may be unsuitable to work in the service. Proof of identity had also been checked.
- All the staff and people we spoke with told us they felt there were sufficient numbers of staff available to support people and care for them in the way they wished to be cared for. The service had recently offered employment to four more staff.

Preventing and controlling infection

- Staff received training in infection control. Staff understood the importance of using protective equipment such as gloves, aprons and shoe covers. People and their relatives confirmed these were used appropriately.

Learning lessons when things go wrong

- Records showed lessons were learnt when situations had not turned out as expected. For example, where staff did not meet the expected standard of care provision, they were retrained. Information was shared with the staff team, and joint learning took place. Both staff and relatives of people using the service told us they thought there was an open culture and they had found when they presented issues to the registered manager things had improved quickly.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People and their relatives told us their needs were assessed before they commenced receiving a service. This enabled both parties to be clear about how the care would be provided and to ensure any additional resources such as equipment were in place.

Staff support: induction, training, skills and experience

- Each new member of staff received an induction which included completion of the care certificate. The care certificate trains staff to know what is required of them to be caring, and equips them with the skills, knowledge, and behaviours to be able to provide quality care. Individuals need to complete 15 standards to be awarded the Care Certificate.
- Additional training was provided to ensure staff understood the needs of the people they were caring for. for example, percutaneous endoscopic gastrostomy (Peg) feeding tubes. This is used to ensure people who have difficulties with oral intake of food and fluid can obtain nutrition directly into the stomach.
- Staff were provided with regular support and annual appraisals. Staff told us they found these useful. One staff member said, "Apart from telling you about your role, you can list if there is any further help you need or how you can expand your knowledge".
- People and their relatives told us they felt staff were suitably trained to enable them to provide safe and appropriate care.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff were trained in food hygiene skills. This was to ensure staff understood the importance of food safety measures when providing food and drinks to people. Staff were aware of the importance of ensuring people received a nutritional diet. When concerned about a person's diet, staff raised this with the registered manager who took the appropriate action and informed the necessary professionals.
- They worked with external agencies to ensure care was consistent, appropriate, and safe. For example, speech and language therapists were used to assess people's ability to eat and drink safely. Where recommendations were made about the consistency and texture of food and drinks, this was recorded and implemented by staff. Occupational therapists, district nurses, the GP, mental health workers and all worked alongside staff to provide care and support to people to help maintain their physical and mental health. Where guidance was provided this was documented in people's care plans.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA

- Staff had received training on how the Mental Capacity Act affected the care provided to people. We were told all the people using the service had the capacity to make their own decisions. Some people's relatives held power of attorney. This gave them the legal right to advocate on a person's behalf, when they were no longer able to do this for themselves. Staff had a basic understanding of the Act, we discussed with the registered manager how this knowledge could be improved through further training.
- The training consultant included the subject of consent in all the training they provided to staff, they discussed how consent was obtained and what staff should do if people withdrew consent. Staff understood the need for people to consent to the care they were receiving.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity, and respect.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity, and independence

- People described staff as "Super" "Friendly and competent". "Very helpful" and "Very Caring". One person who used the service told us the staff were kind, they said when staff arrived at their house they asked them if they wanted to get up out of bed, they did not assume what the person wanted to do. They told us they were always treated respectfully, and their dignity was maintained.
- One person's relative told us how impressed they were with the quality of care provided to their family member. They told us "They arrive on time, they are always cheerful, if they have got problems they don't bring them into the house... They look him in the eye and ask him how he feels, if he has everything he wants and if there is anything else he needs".
- Another person told us the care their relative received was excellent. They spoke about how they had not had a good experience with a previous care provider, but Affection Care Ltd had impressed them. They told us the staff were knowledgeable and care was consistent. They described the staff as "Kind and considerate", they appeared to be "very gentle" when providing care to their family member.
- People and their relatives told us they were treated fairly. One staff member told us "Everyone is treated equally". We were told how staff respected people's homes and families as well as the people they were caring for. They told us how people's privacy was respected by closing doors when personal care was being provided and by telling or asking people before they carry out any tasks.
- One staff member told us "We show respect by making sure we are informing them of what we are doing. Treating them how we would want to be treated". Another staff member told us "You can show respect by the tone of your voice, the way you speak to people and your body language. You have to be aware of this when you care about their feelings".

Supporting people to express their views and be involved in making decisions about their care

- People and their relatives told us they felt "Comfortable" to raise concerns and make suggestions about the care being provided. Staff told us one person who spent a lot of time at home had told staff they would like to go out. They told us how they volunteered to support the person out in the community, they told us even though this was not part of their care package the person was "really happy".
- One person's relative told us, if they had to speak with the registered manager about any concerns or issues, they responded quickly. A person described to us how they felt they had been listened to, they said they had spoken to the registered manager, because they did not want to go to bed at the time scheduled for carers to visit. This was rescheduled to a more appropriate and agreeable time.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Improving care quality in response to complaints or concerns

- Care plans were written in a way that was person centred. This meant the specific needs of the person had been highlighted and how the service was going to meet their individual needs had been agreed and recorded. People were given the opportunity to feedback to the provider at any time.
- Records showed when the training consultant carried out spot checks on staff and their performance, they also took the time to ask people for feedback. Comments we read included "[Named person] stated that the carers are very good and do their best. She also stated the office manager are very good too and always listen". And "[Named people] are very happy with the care they receive. Both feel the carers do a great job and are always kept informed of any changes".
- At the time of our visit there had been no official complaints made to the service. One relative told us if there was anything they had been unhappy with they had raised it directly with the staff or the registered manager, and things had improved. They felt as the service had developed, and the staff had got to know the person, the quality of the care had improved and there was less to complain about.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Staff were offered training in how to communicate with people, this was included in their mandatory training. A person who has a sensory disability was offered extra resources to assist with understanding their care plan. The person declined the offer and found alternative ways to be able to understand their care plan and associated records. The majority of people could communicate verbally with the staff.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.

- At the time of our visit staff were not supporting people with social activities. However, staff told us how they sat and chatted to people if they had time. One staff member told us how they sat and spoke with a person about their previous career and books. The person's relative confirmed this happened and their family member enjoyed these occasions.
- Staff also spoke about how they could support people to access their local community. Currently this was not part of people's care plans, but something people had expressed an interest in doing.

End of life care and support

- The service was not providing end of life care at the time of our visit. Staff were not trained in this area of care. Care plans did not include people's wishes. When we spoke with one person's relative, they told us the person had a living will in place. (A living will, allows a person to refuse medical interventions, even if it would save their life. It is legally binding which means that those caring for a person must follow their instructions.) We asked if this had been shared with the provider, they told us it had not and was something they would do in the near future.
- The registered manager told us they were planning to offer training to staff in this area, so they could offer the best possible care.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was still under development. Leaders and the culture they created did not always support the delivery of high-quality care in all areas.

Managers and staff being clear about their roles, and understanding quality performance, risks, and regulatory requirements

- Management had failed to recognise some areas of the service that required improvement,
- During our inspection we found the management of medicines needed improving. We examined the medicines audit form. We discussed with the registered manager how this could be improved upon. The improvements would enable a clearer oversight of how medicines were being administered and recorded. Other audits had been carried out in areas such as care planning, training, and personnel file audits.
- We discussed with the registered manager how often they reviewed the care for people. They told us there was not a set time, but "As and when". The registered manager agreed the care plans needed to be reviewed on a more regular basis.
- We found food allergy risk assessments were not in place. This placed people at risk of harm.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service had been operational for one year. During this time the registered manager had developed their management skills. This in turn had seen an improvement in the service provided to people. In their discussions with us they did not shy away from areas that were identified as requiring improvement and viewed the inspection as an opportunity to learn.

Care plans were under review with possible changes being implemented. Staff training was being developed and personnel files were up to date.

- The registered manager told us the introduction of an office manager and enlisting the services of a training consultant enabled them to focus more closely on the performance of the service. It allowed them the time and space to review the service and to make the necessary changes to drive forward improvements.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Care plans were person-centred and inclusive. People's relatives told us they had read the care plan and it accurately reflected the care being provided. The provider was clear that their aim was to "Provide the best care service in the whole of Bucks". They had a vision on how they were going to achieve this through the

development of staff. The office manager told us "Their (staff) development means more to us than anything else, as this ultimately rubs off on the people we care for".

- People's relatives, one person and staff told us they liked the management, comments included, "As well as supporting the clients they support us too. You want to know you are working for a company who care for you too". A person's relative told us "If I have been unhappy about something I have spoken to [Named registered manager], she is very approachable and a very nice person, I like her very much". They told us the registered manager asked them if any improvements could be made to the care provided. They felt the service was well managed.
- One person's relative told us they could see the improvements in the service as the staff became more experienced and settled.
- Discussions had taken place between the three senior staff about how the service could be improved, what the training and the environmental needs of the service were. The week following our inspection the office location moved to enable the staff to have more space when training or meeting.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- The registered manager was aware of their responsibilities under the duty of candour. When incidents occurred, they fulfilled the requirement of being honest and open with people. Records demonstrated people were informed and apologised to if the situation required it.

Continuous learning and improving care

- Staff told us communication with the provider and senior staff was good. Learning and improving the service was a key objective for the provider. Monthly staff meetings and weekly managers meetings allowed for discussions around how the service could avoid accidents and repeat incidents. Learning from experiences, for example the training consultant did not feel they were getting enough time with staff. This had resulted in recruitment of more staff. The aim was to train sufficient numbers of staff to ensure they had the skills to carry out their roles.

Working in partnership with others

- The service worked in partnership with people and their relatives. They also worked with several other agencies and professionals, these included commissioners of care and practitioners such as health professionals. Where advice was given this was followed by staff, for example one person had a pressure sore, guidance was given by the district nurses on how to assist with healing of the skin. Through partnership working and cooperation the person no longer had a pressure sore and the skin had healed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider failed to ensure the proper and safe management of medicines and assess the risks to the health and safety of service users of receiving the care or treatment;</p> <p>Regulation 12 (1) (2) (a) (b) (c) (f) (g).</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>People who use services and others were not protected against the risks of harm as the provider had failed to provide effective governance, including assurance and auditing systems or processes. They failed to assess, monitor and drive improvement in the quality and safety of the services provided.</p> <p>Regulation 17 (1) (2) (a) (b) (c)(d) (i) (e) (f)</p>