Agincare UK Limited

Agincare UK Andover

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

Agincare UK Andover provides personal care and support to people in their own homes. The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care', that is, help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of our inspection the agency was providing a service for 36 older people with a variety of care needs, including people living with physical frailty or memory loss due to the progression of age.

A registered manager was not in post at the time of our inspection. 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. A new manager had started with the service and will be applying to register with the commission.

People's Medication Administration Records (MARs) were not always recorded appropriately and not all staff had been assessed as competent to administer medicines.

People felt staffing levels were not always consistent and timings could be improved especially at the weekend. Recruitment checks were safe.

People using the service and their relatives told us they felt safe. Staff understood and followed guidance to enable them to recognise and address any safeguarding concerns about people.

Most staff received regular support and one to one sessions or supervision to discuss areas of development. However, direct observations and supervisions had fallen behind for some staff. Staff completed a range of training and felt it supported them in their job role. New staff completed an induction before being permitted to work unsupervised.

People's safety was promoted because risks that may cause them harm had been identified and were managed appropriately. There were plans in place for foreseeable emergencies. Staff contacted healthcare professionals promptly when they had concerns about people's health and wellbeing.

Staff were able to identify and discuss the importance of maintaining people's respect and privacy at all times. People were encouraged and supported by staff to make choices about their care.

People knew how to complain and told us they would do so if required. People and relatives were encouraged to provide feedback on the quality of the service during regular telephone quality assurance checks.

Care plans provided comprehensive information about how people wished to receive care and support. This helped ensure people received personalised care in a way that met their individual needs. People were

supported with their nutritional needs when required. Staff were aware of people's likes and dislikes.

Staff felt supported by the management and felt they could visit the office and be listened to. Regular audits of the service were carried out to assess and monitor the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service remains requires improvement.

Staff were trained to support people with medicines. However, there were some gaps in medicine administration records and not all staff had been assessed as competent to administer medicines.

People felt staffing levels were not always consistent and timings could be improved especially at the weekend.

People felt safe and secure when receiving support from staff members. Staff received training in safeguarding adults and knew how to report concerns. Risks to people's welfare were identified and plans put in place to minimise the risks.

Is the service effective?

Requires Improvement

The service not always effective.

Where there were concerns about people's capacity to consent to decisions about their care, the provider did not make appropriate guidance when making decisions in people's best interest.

Staff received appropriate training and one to one supervisions. However, supervisions had fallen behind and some staff had not received direct observation to observe they were providing effective care.

People were supported to access health professionals and treatments, and were supported with eating and drinking.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Good

The service remains responsive.

Is the service well-led?

Good

The service remains well led.

Agincare UK Andover

Detailed findings

Background to this inspection

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

This inspection took place on 24 and 26 September 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure staff would be available to speak with us.

The inspection team consisted of one inspector and one expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed information we held about the service. We checked to see what notifications had been received from the provider. We did ask the provider to complete a Provider Information Return (PIR) before our inspection. This 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. However, there was an error in receiving the information, so we did not receive this information in time for our inspection.

During the inspection we spoke with 10 people receiving care and support and 10 relatives by telephone. We spoke with the area manager, the newly appointed manager, administrator, and seven staff members. We looked at care records for five people, medicines records and recruitment records for five care staff. We looked at other records in relation to the management of the service, such as health and safety audits, minutes of staff meetings and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in June 2016 we identified records relating to the administration of medicines were not always accurate. At this inspection we identified further improvements were still required.

People were not always protected against the risks associated with the unsafe management and handling of medicines. Records we looked at showed people had received their medicines as prescribed, but this was not always recorded in line with best practice. Some medicine administration records (MARs) had missing signatures. For example, records showed for one person on the 01 July 2018 staff had reported there was no MAR chart in the persons home to record medicines and this was not put in place till the evening of the 13 July 2018, which meant staff were unable to record that people had received their medicines as prescribed. Other MAR's showed gaps in records. The MAR chart provides a record of which medicines are prescribed to a person and when they are given. The provider's medicines policy stated that staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine.

The medicines care plans and MARs did not contain any guidance or information to support the administration of "when required" (PRN) medication. This meant staff did not have access to information to assist them in their decision making about when such medicines could be used, for example if people were in pain. Most people had risk assessments in place for their medicines. However, most of these contained very little information to support staff to ensure medicines were administered safely and person centred.

Staff had received training for the safe handling of medicines. However, records did not evidence that all staff had received an annual assessment of their competency to administer medicines in line with best practice guidance and the provider's policies and procedures. We spoke to two staff members who told us they had been working for the agency a year and no one had checked their competency to administer medicines safely.

People and their relatives told us they felt safe. One person told us, "Yes. I'd phone up the office". A relative said, "Yes. If not, he'd tell me and I'd report it to Social Services". Another relative told us, "Yes. It's the same lady all the time, it's practically one on one".

People received a weekly schedule of when staff would be visiting them and knew in advance which member of staff it would be. We received mixed views from people about staffing. One person told us, "It's different times with different people. There's a rota but they don't always keep to it. There's changes in times". A relative said, "The list gets here later than it should or the person is not the person on the list. Sixty or seventy % of the time it's alright. The post comes here late, I have told them in the office". Other people told us it was improving and that they have never been sent a person they didn't know.

People and their families also told us the carers didn't always arrive at the times they wanted. For example, one relative told us, "They do try to give you a regular time and I appreciate they can't always keep to that, things do happen. But it depends on who's running things, like it's worse at the weekends. They do mess you about quite a lot. They are supposed to come at 7.00pm in the evening and at 6.30pm you get a call; they're

going to be late, they can come at 9.30pm. Now that's too late for her. I feel they do it so you will cancel. They get paid anyway and Agincare couldn't care less". Another relative said, "Time wise this week it was [staff members name]. She was supposed to come at quarter to nine, but she came at 10.30am. [Staff members name] she's very good, she told us she was told to come at 10.30am". Other comments included, "They're not silly late". One staff member told us, "Staffing I think at weekends we struggle with staff but week days are okay".

Records showed that most people had consistent times scheduled, although one person's schedule showed lots of different times throughout the day and evening. We spoke to the area manager and new manager about our concerns, who told us they were working closely with office planning staff to improve consistently for people to make improvements.

Staff understood their safeguarding responsibilities. A safeguarding policy was available and staff were required to read this and complete safeguarding training as part of their induction. Staff members were knowledgeable in recognising signs of potential abuse and the relevant reporting procedures. Staff told us if they had any concerns they would report them to their manager, and if no action was taken would take it higher up.

People were protected by staff who understood and were confident about using the whistleblowing procedures. Whistleblowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. All the staff we spoke with were aware of how to use the policy.

Recruitment processes were followed that meant staff were checked for suitability before being employed by the service. Staff records included an application form, two written references and a check with the disclosure and barring service (DBS). DBS checks help employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Assessments were undertaken to assess any risks to people and to the care workers who supported them. Areas covered by these assessments included risks associated with the environment, behaviours, health conditions and moving and handling. Plans set out how risks were minimised or prevented, for example ensuring the home environment was free from trip hazards.

Records were maintained of accidents and incidents which occurred. There was evidence that that the manager reviewed these to ensure that appropriate action had been taken and to debrief the staff involved.

The service had a business continuity plan in case of emergencies. This covered eventualities such as severe weather conditions, loss of power, fuel shortages, staff shortages, and the office and equipment being inaccessible. This contained a set of procedures to follow and emergency contacts for staff.

Staff demonstrated a good understanding of infection control procedures. All had received training in infection control and had ready access to personal protective equipment, such as disposable gloves and aprons.

Requires Improvement

Is the service effective?

Our findings

People told us that staff were well trained and supported them in the way they liked. One person told us, "If I ask for something, they don't mind, they just get on with it. That's very good for me". Another person said, "They're brilliant. They do a good job. They do what I need". A relative said, "They come out with the new ones, they shadow. They come out with [staff members name], he's very good".

Before providing care, staff sought verbal consent care from people and gave them time to respond. Staff were aware people were able to change their minds about care and had the right to refuse care at any point. People told us they had been involved in discussions about care planning and we saw people had signed their care plans agreeing to the care the agency intended to provide.

Staff had received training in the Mental Capacity Act, 2005 (MCA). 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.

However, we noted that one person's medicines had been locked away out of their reach. We were unable to see evidence that this had been agreed as part of a best interests decision following the completion of a mental capacity assessment. We discussed this with the manager, who told us they would liaise with the community mental health team to review this practice and ensure that all legal requirements were being met and the person's human rights protected.

People told us new staff members were accompanied by a regular staff member and shown how people liked things done. New staff completed an induction programme before working on their own. Arrangements were in place for staff who were new to care to complete the Care Certificate. This certificate is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate support to people.

People were supported by staff who had access to a range of ongoing training to develop the skills and knowledge they needed to meet people's needs. Training records showed most staff were up to date with mandatory training which was refreshed annually. Training was a mixture of class room based and online training using workbooks as well as practical training on moving and handling.

Some planned supervisions of staff, appraisals and competency checks of staff had not always been taking place. Supervisions and appraisals are processes which offer support, assurance and learning to help care staff develop in their role. We were advised that this was because the service had been without a manager for a period but that this was now an improving picture which records appeared to confirm. These improvements need to be embedded.

People were supported at mealtimes to access food and drink of their choice. One person told us, "If I want

them to, they would make me a sandwich or a salad". A relative said, "It's [a meal] prepared for her by the carer. They give it to her and wash up afterwards". The support people received varied depending on their individual circumstances. Some people lived with family members who prepared meals. In other cases, staff members reheated meals and ensured they were accessible to people. Care plans contained information about specific food preferences and most were suitably detailed about the support people needed with their nutritional needs.

People were supported to access healthcare services. Staff told us they would always inform the office to keep them updated about any changes in people's health. If any health professional had visited staff told us they would call the office to let them know, so the next staff member was aware of the persons current health needs and any action needed.

Good

Is the service caring?

Our findings

People and their relatives told us they were cared for by staff who were kind, caring and compassionate. One person told us, "They [staff] are very, very kind and very, very respectful". Another person said, "Especially [staff member's name], she's lovely. She's really nice". A relative told us, "The carers are absolutely wonderful, I can't fault them. There's never been a bad one". Another relative said, "They sit and talk to him, it's nice. They are all friendly and do their job well". Other comments included, "I've heard how they speak to him, they're really good". As well as, "They are very kind".

People and their relatives told us they were treated with dignity and respect. Staff explained how they respected people's privacy and dignity, particularly when supporting them with personal care, by for example, ensuring doors were closed and people were covered up.

People were encouraged to be as independent as possible. One relative told us, "They say to him and encourage him. He's only paralysed down his left side, they encourage him to wash as much as he can with his right side".

Care staff knew the level of support each person needed and what aspects of their care they could do themselves. They were aware that people's independence was paramount and described how they assisted people to maintain this whilst also providing care safely.

People were supported to express their views and to be involved in making decisions about their care and support. Records showed people and their relatives were regularly asked if the care they were receiving was meeting their needs or if changes were required. Staff were able to explain how they supported people to express their views and to make decisions about their day to day care. This included enabling people to have choices about what they would like to eat or the support they required during that visit.

Information regarding confidentiality, dignity and respect formed a key part of induction training for all care staff. Confidential information, such as care records, was kept securely within the registered manager's office and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected. Daily records were collected monthly and stored securely in the relevant care files at the office.

Good

Is the service responsive?

Our findings

People told us the agency were responsive to their needs and preferences. A relative told us, "We've asked if they can come earlier when she goes out. They said they would do their best. The manager said she'll come on Friday to look at it". Another relative said, "We've got no complaints; they even worry about me".

People's needs were assessed assessments and care plans were then developed outlining how those needs were to be met. The care plans provided information about how people wished to receive care and support. The care plans seen was very detailed and provided carers with the person's life history and their desired outcomes from the care and support. The care plans described people's needs in a range of areas including personal care, daily living activities, and meal preparation. Care plans reflected people's individual needs and were not task focussed.

People's satisfaction with their care and support was reviewed each month through the use of telephone surveys. We looked at records for August 2018 which showed 22 people had received a telephone call. These showed most people were happy with care staff. Two people has asked for their care visits to be later in the morning. As a result, reviews had been arranged with these people to discuss their needs.

The provider also sought feedback from people or their families through the use of a quality assurance survey. This was sent out annually seeking their views. At the time of our inspection the service was still awaiting the results of the latest quality assurance survey, so we were unable to view the results from the latest questionnaire.

We received mixed feedback about how the service managed complaints. One person told us that when they phoned the office to complain it had been looked into it. However, one relative told us their complaint hadn't been resolved to their satisfaction. They said, "Generally, I'm happy with the carers, but not with the company. I've asked them to call me multiple times and I've never got a call". Records showed complaints were listed and we could see responses to people's complaints. But for one person it was not clear to see that a response had been made to the complainant. We spoke to the area manager about this complaint. They told us, it had been resolved and that they had had a meeting with the complainant, but there was no further documentation regarding this.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Records showed communication care plans were in place and provided information to support staff care and interact with people who had difficulties in communicating.

Good

Is the service well-led?

Our findings

People and their relatives told us they were overall happy with the service. One person told us, "They do listen to what I'm saying". One relative told us, "The office staff are always great. We are very, very happy. I will say, they always answer the phone. You never have to leave a message and hope they get back to you. It's brilliant". Another relative said, "They seem to listen and take things on board". "We've never had a real problem. Someone always gets back to you. They always give you an answer. They try their best".

The service had been without a registered manager for a few months however a new manager has recently been appointed and started on the second day of our inspection. Staff told us that they felt supported throughout and felt it hadn't affected them as support had been arranged to cover the service.

One staff member told us, "I feel supported, if I have any issues or problems I can ring up the office. For example, a service user was poorly so I phoned up the office and they covered my calls". Another staff member said, "I feel really supported. If there are any issues straight away they are dealt with, I feel I have back up here. Even without the manager the ladies in the office really pulling together, especially [staff members name] who has been outstanding we have also had the area manager. Wouldn't know we didn't have a manager. [Staff members name] held the place together well". Other comments included, "Office staff very supportive. They have managed without a manager and done really well". As well as, "I have enjoyed my time. Find they accommodate me very well. Very flexible as was on maternity leave and very good with me changing my hours, which lowered the pressure after having the baby".

The senior team in the office promoted a positive culture and had an 'open door' policy. Staff told us they felt welcomed in the office at any time. Staff meetings were held for all staff to discuss any concerns and share best practice. These informed staff of any updates on people's health and training opportunities. One staff member told us, "It's good to get together and share best practice you learn quite a bit to be honest". Staff were also updated by a quarterly newsletter and to celebrate success and share advice.

The provider used a system of audits to monitor and assess the quality of the service provided and help drive improvements. These included medicines, care plan, staff files, complaints, safeguarding and incidents and accident audits. For example, a recent medicine audit showed that some risk assessments needed to be updated and two people needed PRN care plans. Actions were that these would be completed by the middle of October 2018. This confirmed that records had been reviewed to ensure that they contained the correct and most up to date information and that guidance was available to staff on how to deliver care effectively.

The regional manager completed a quarterly audit. The results of these quality assurance audits were used to identify where improvements could be made to the service provided. Part of these included the area manager gathering feedback by telephone on the quality of the service to at least one person. Records showed from a recent audit that the person was very happy with the service provided.

The provider had appropriate polices in place as well as a policy on Duty of Candour to ensure staff acted in

an open way and transparent way in relation to care and treatment when people came to harm.