Alpha Home Assist Limited

Alpha Home Assist

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We completed an announced inspection at Alpha Home Assist Limited on 21 and 24 February 2017. This was the first inspection since the service re-registered with us after moving location on 22 December 2016.

The service is registered to provide personal care to people in their own homes. At the time of our inspection eight people were using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At this inspection, we identified Regulatory Breaches. You can see what action we told the provider to take at the back of the full version of the report.

Medicines were not administered in a safe manner.

Although risks to people's health and wellbeing were assessed and planned for, staff did not always have the knowledge and skills needed to meet people's needs in a safe and effective manner.

People did not always receive their care in accordance with their agreed needs and preferences. Care was not always delivered at people's agreed and preferred times.

Care calls were not always planned in a caring manner. Staff were not deployed effectively to consistently meet people's care needs and preferences. There was evidence of call cramming which meant some care calls were planned too close together, so staff could not provide people's care at their planned times.

Effective systems were not in place to consistently assess, monitor and improve the quality of care. Some staff did not know how to identify and report abuse to promote people's safety and wellbeing.

Effective systems were not in place to ensure consent to care was gained in accordance with legislation. Records did not show that the requirements of the Mental Capacity Act 2005 were consistently followed.

Complaints about care were not always managed in an effective and responsive manner.

People were supported to eat and drink in accordance with their care preferences. However, people could not always be assured that they were supported to eat and drink specialist diets safely.

Some care preferences were recorded for staff to follow. However, improvements were needed to ensure all important care preferences were assessed and recorded to ensure people's care preferences were

consistently met.

Effective systems were not in place to ensure people's feedback was acted upon to ensure their care preferences were met.

People were supported to access health and medical support when required.

Staff promoted people's privacy and dignity and people told us they were treated with kindness and respect.

Staff were recruited safely and people felt safe around the staff.

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 was not consistently safe. Medicines were not managed safely.

Risks to people's health and wellbeing were assessed and planned for, but staff did not always have the knowledge and skills needed to keep people safe. Safety incidents did not always trigger reviews of people's risks to prevent future harm from occurring.

Staff were not effectively deployed to provide people's care at the agreed times.

Some staff did not know how to identify and report abuse to promote people's safety and wellbeing.

Staff were recruited safely and most people felt safe around the staff.

Is the service effective?

Requires Improvement

The service was not consistently effective. Staff did not always have the right knowledge and skills to meet people's needs in a safe and effective manner.

Improvements were needed to ensure that people's consent to care was formally sought in accordance with legislation.

People were supported to eat and drink in accordance with their care preferences. However, we could not be assured that people were consistently supported to eat and drink in a safe manner, in accordance with their care plan.

People were supported to access health care professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring. A caring approach to planning people's care was not used by the registered manager and provider. As a result, people didn't always get their care at the agreed times.

People were treated with kindness and respect.

Privacy and dignity was promoted and people were enabled to make decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People did not always receive their care in a manner that reflected their agreed needs and care preferences.

Effective systems were not in place to ensure feedback and complaints from people and their representatives was acted upon in a responsive manner.

People and their representatives were involved in the assessment and review of their care. However, improvements were needed to ensure important care preferences such as the timing of care calls were assessed, recorded and met.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Effective systems were not in place to asses, monitor and improve the quality of care.

Staff felt supported and enjoyed working at the service.

Plans were in place to involve people in the assessment and monitoring of care as the provider planned to complete a care satisfaction survey. We will check this has been implemented effectively at our next inspection.

Alpha Home Assist

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 was 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.

We undertook an announced inspection of Alpha Home Assist on 21 and 24 February 2017. We gave the provider 24 hours' notice as we needed to ensure that staff were available when we visited the office. This inspection was completed in response to concerns that had been shared with us about the quality of care.

Our inspection team consisted of three inspectors. This was because we needed to visit the office, make phone calls to staff and people who used the service and we also visited some people who used the service in their own homes. We checked the information we held about the service and provider. This included the information we had received from the public and local authority. We used this information to formulate our inspection plan.

With their consent, we visited three people who used the service in their own homes and through phone calls we spoke with the representatives of two other people who used the service. We did this to gain people's views about the care and to check that standards of care were being met. We also spoke with three members of care staff, the registered manager and the provider.

We looked at the care records of four people who used the service to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included staff files, rotas and training records.

Requires Improvement

Is the service safe?

Our findings

Effective systems were not in place to ensure people's medicines were managed safely. One person was at risk of receiving too much of their prescribed pain medicine within the recommended time period because their morning and lunch calls were planned too closely together. This person frequently declined their lunch time medicine; therefore at the time of our inspection, this planning error had not resulted in an accidental medicines overdose. However, this planning error had and continued to place this person at risk of potential harm to their health, safety and wellbeing.

Another person's care records showed that staff assisted them to take their medicines. However, no medicines administration records (MAR's) were kept to guide staff about which medicines to give the person and when to give them. This meant the person was at risk of receiving their medicines in an unsafe or unsuitable manner. Because there were no MAR's in place for this person, we were unable to identify what medicines the staff had supported the person to take and when this support had been given. This meant we couldn't be assured that the person had been supported to receive their medicines in a safe manner.

Care records showed that risks were assessed and planned for. However, we found that staff did not always have the knowledge required to manage people's risks. For example, one person's care records showed they were at risk of choking. The information in this person's care plan detailed the amount of thickener that needed to be added to this person's drinks to reduce their risk of choking. We asked three staff members how much thickener they added to this person's drink when they prepared it for them. Two staff gave us the correct information and one staff member gave us information that did not match the care plan. This meant the person was at risk of receiving unsafe care from this staff member.

We found that safety incidents did not always trigger a review of people's risk of harm to their health, safety and wellbeing. One person's care records showed they were at risk of falling and they had fallen recently during a period of respite care with another care provider. This fall had not triggered a review of their risk of falling again or a formal assessment to ensure that their care needs had not changed. The provider told us they had, "Asked the family if we needed to update anything and staff would have told us about any changes". This meant the registered manager and provider had not formally assessed the person's risk of harm by completing a reassessment of the person's risk of falling or their care needs.

The above evidence demonstrates that effective systems were not in place to ensure people received their care in a safe manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us that they did not always get their care at the agreed times. Some people said this was sometimes an inconvenience, but not a major problem for them. Comments from these people and their representatives included; "I'm used to them coming at different times, as long as they turn up its okay", "There's no effect on [person who used the service] if they are late, they are just glad they've come" and, "If they are late, I'm usually up as I can see to myself". However, some people and their representatives told us that early or late calls had an impact on their health, safety and wellbeing. For example, one person and

their represented told us, "They don't come on time" and, "They are gradually getting earlier". Care records showed staff were visiting this person earlier than planned. On one recent morning, care records showed the staff had visited the person 30 minutes earlier than planned. The person's representatives said, "It's too early, but we put up with it as we know what care is like". They also told us that when care staff visited earlier than planned, they left earlier than planned. They said, "[If they arrive earlier than planned] they sometimes leave before 8am, so [person who used the service] is on their own until I get here". This person's care plan stated that they were, 'supervised by family at all times'. This meant that when carers started this person's care call early, they left before family were available to supervise the person as planned, placing them at risk of harm to their health, safety and wellbeing.

Care rotas showed evidence of 'call cramming'. Call cramming is when visits are planned too close together which means people are at risk of not getting the care they need when they need it. For example, we saw one staff member's rota regularly showed they needed to start one person's care call at the same time that they were due to finish another person's care call. This rota did not allow for any travel time between these two calls which meant the staff member would consistently be late for the second person's care calls. This person's care records showed that staff had been at least 30 minutes late to their morning care call on at least six of the 10 days of care records that we viewed. The latest call was 55 minutes late. This showed call cramming had resulted in people receiving their care calls later than their agreed time, placing people at risk of harm to their health, safety and wellbeing. We told the provider that call cramming was not acceptable practice. They responded to this by saying, "Some service users have stated calls can be flexible" and, "It's not causing issues". Call cramming is an unsafe approach to care and places people at risk of harm. The provider told us they felt there was enough staff working at the service. They informed us the late calls were due to traffic and the reliance of public transport. They said, "There have been some recent delays due to traffic and roads works. Also, some staff don't drive" and, "At the moment we have enough staff".

We found that staff did not always know how to identify and report suspected abuse or neglect. Two of the three care staff we spoke with knew how to identify and report abuse. However one member of care staff did not. This staff member told us if they identified unexplained bruising or marks on a person's body, they would, "Write it down quickly and tell them [person who used the service] to go to their GP". We also found that action was not always taken to protect people from the risk of potential abuse and neglect. One person's care records contained a body map that showed staff had identified unexplained bruising on the person. Care records did not show that this unexplained bruising had been reported to the registered manager, provider or the local safeguarding team. Because the registered manager had not been informed of this bruising, it had not been recorded as an incident or safeguarding concern. This meant effective procedures were not in place to ensure staff identified and acted upon potential safeguarding concerns.

Some people and their representatives told us they felt safe around the staff. One person told us how they felt safe bathing with the staff present. They said, "Yes I feel safe, they are just there if I need help". One person's representative told us how they felt their relation was supported by staff in a safe manner. They said, "If they help [person who used the service] to walk, they stand very close to her for support". Staff told us and we saw that recruitment checks were in place to ensure staff were suitable to work at the service. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service.

Requires Improvement

Is the service effective?

Our findings

Some people and their representatives told us they were not always confident that the staff had the knowledge and skills required to meet people's needs and keep people safe. One person's representative said, "Some of the things they don't do are common sense" and, "They're not bad, they are just not thinking". Another person's representative told us they had asked for changes to be made to their relation's care plan as they felt staff, "Didn't know how to do this (deliver that specific part of the person's care) properly". Staff told us and training records showed that some training had been provided. However, we found that training had not always effective because there were some gaps in the staffs' knowledge and skills which meant people had received and were at risk of receiving unsafe and ineffective care. For example, training records showed that all staff had received medicines training, but medicines were not being managed safely. Training records also showed that all staff had received training in safeguarding adults. However, at least one staff member had not understood this training as they did not know how to protect people from the risk of abuse and neglect.

Some people told us that staff sought their consent before they provided care and support. One person said, "Yes, they always check with me first". However, we found that the registered manager did not always ensure that consent to care was consistently sought from people who used the service. We also found that the requirements of the Mental Capacity Act 2005 (MCA) were not always followed, to ensure people received care that was suitable and in their best interests.

The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Care records showed that mental capacity assessments were not always completed accurately and in accordance with the MCA to identify if people had the ability to make decisions about their care. For example, one person's consent to care form had been signed by their representative, so we looked to see if the person's ability to consent to their care had been assessed. A mental capacity assessment had been competed which said the person did not have capacity. However, it was not clear what decision this mental capacity assessment related to as no specific decision had been recorded. We asked the registered manager if this person had capacity to consent to their care. They said they felt the person did have capacity to consent to their care as they could understand and communication information about their care needs. Therefore, we asked why the person hadn't signed the consent form themselves if they had capacity to do so. The registered manager told us, "I don't know, it must be a mistake". This meant we couldn't be assured that this person had formally consented to their care.

People told us that they were supported to eat and drink in accordance with their care preferences. One person said, "I tell them what food I want" and, "They always make sure I've eaten". Care records confirmed that people received support to eat and drink if this was planned for and required. However, we could not be assured that people were consistently supported to eat and drink safely. This was because one staff

member did not know how to prepare one person's specialist food and drinks in accordance with their care plan.

People and their representatives told us that staff offered support in response to changes in their health or social care needs. One person said, "They offer to call the GP for me if I'm ill". A person's representative said, "The manager has asked social services to do a review as [person who used the service] needs more time in the morning". This showed that people were supported to access support from health and social care professionals when needed.

Requires Improvement

Is the service caring?

Our findings

The registered manager and provider did not have systems in place to ensure that people's care was consistently planned in a caring manner. Care calls were frequently late, which posed a risk to people's health, safety and wellbeing and call cramming was also evident in the staff rotas. One person's representative told us how their relatives care calls were frequently not at the agreed times. They said, "I feel they are taking advantage". This was an uncaring approach to planning people's care calls.

People told us that the staff treated them with kindness and respect. Comments from people and staff included; "I find them caring", "They look after me and help me" and, "They are polite and kind". People and their representatives gave us examples that showed how the staff treated them and their relatives with kindness. One person said, "The manager just popped in to say hello. She does that a lot and asks me if I need anything from the shop". A person's representative said, "They hold their hand and ask how they are".

People told us that their care was provided in a dignified manner. For example, one person told us how staff encouraged them to be as independent as they could be which was important to them. They said, "They definitely try to encourage independence". A person's representative confirmed that their relative was treated with dignity and respect by saying, "Dignity and respect isn't an issue".

People and their representatives told us that the staff knew them and their relatives well. One person told us how one of the staff made them a cup of coffee just how they liked it when they visited. A person's representative said, "They know [person who used the service] and they know where things are. [Person who used the service] likes them and is happy with them". People and their representatives also told us that care was mostly delivered from the same care staff which provided them with consistency. One person said, "I get continuity, so they know me well". A person's representative said, "We get the same carers so far. We asked them to send the same one's so they can get used to them".

People told us their privacy was promoted. One person's representative said, "The bedroom door is always open, so they just pop their head round to say hello before they go in". People confirmed they were involved in making choices about their care. For example, people told us that staff asked them what clothes they would like to wear and what meals they would like to eat.

Following our inspection, the provider submitted additional evidence to demonstrate some recent caring interventions. They told us that they and some of their staff had attended the funerals of two people who they had supported to use the service. They also told us they had arranged a birthday celebration for a person who used the service who lived alone. They told us this had cheered the person up. We were unable to confirm this information with this person due to receiving this information after our inspection had been completed.

Requires Improvement

Is the service responsive?

Our findings

Some people told us they didn't always receive their care at their preferred time. For example, one person's representative told us they had agreed set times with the registered manager and provider. However, they told us that their relative's calls were not delivered at this agreed time. This person's care records and call logs also confirmed this. This person and their representative told us that not receiving their care calls at the agreed times meant they were not supported to get up in a morning and go to bed in an evening at their preferred time. They also told us that because they were consistently supported to go to bed and take their evening medicines earlier than requested, they suffered the effects of their medicines earlier than planned. For example, one of the evening medicines that was administered earlier than agreed was a fast acting sedative which made the person sleepy. The person told us this made them fall asleep early than they would have preferred.

Some people and their representatives also alleged that staff did not stay for the agreed length of time. One person's representative said, "[Person who used the service] regularly gets short calls". Another person's representative said, "The morning care call is often short". We viewed the call logs for one of these people which confirmed the carers often left the person's home before the agreed care time had been met. For example, over an eight day period just prior to our inspection, all the person's morning calls were shorter than planned. This meant people were not always receiving the care they had agreed to for the amount of time they had been assessed.

We received mixed feedback from people and their relatives regarding the management of complaints. Most people and their representatives told us they had not needed to make a complaint, but they were confident any complaints would be acted upon. For example, one person's representative said, "I would hope complaints would be dealt with" and, "I've got nothing bad to say, it's a relief to be having extra help". However, some people told us complaints were not always managed in a prompt and responsive manner. One person told us their complaint was resolved, but it took time to address their issues. They said, "Complaints have been responded to" and, "The manager is busy, but things get dealt with in the end". A person's representative told us they had started to write their comments and concerns in the care records as well as contacting the registered manager and provider. They said, "I want them to up their game". We found that prompt action was not always taken in response to people's feedback about their care. For example, one person's representative had recently contacted the provider and recorded a concern in the care records about their relative's care calls not being delivered at the agreed time. Care records showed that prompt action was not taken to act upon this feedback as the person had continued to receive their care calls at a time they had not agreed to. When we viewed the complaints log for the service, this complaint had not been logged by the provider. This meant we could not be assured that complaints were being managed in an effective and responsive manner to make improvements to people's care experiences.

People and their representatives told us they were involved in the assessment and review of their care. One person's representative said, "The manager came out recently to do a review". Another person's representative told us that their relative had requested that they only received care from female carers during their assessment. This person's care records reflected this which confirmed the person had been

involved in the assessment process. Most care records contained detailed information about how people wanted to receive care. However, improvements were needed to ensure important care preferences were assessed, recorded and met as three of the four care records we viewed did not record people's preferred care call times. Therefore we could not always identify if people had received their care in accordance with their care preferences.

Requires Improvement

Is the service well-led?

Our findings

We found that the systems in place to assess, monitor and improve quality were not always effective. The registered manager and provider told us they completed care record audits on a regular basis. However, audit records showed that only one person's daily care records (records care staff recorded care delivery in) had been audited since the provider re-registered with us on 22 December 2016. No care plans had been audited alongside the daily care records to ensure care plans were accurate and up to date. This meant the issues we identified around consent to care and people's care call time preferences not being recorded had not been identified and acted upon to ensure care records were accurate and up to date. Inaccurate and out of date care records places people at risk of receiving unsafe and unsuitable care.

Daily care records were always returned to the office in a timely manner to enable the registered manager and provider to complete audits of their content. The registered manager told us, "Some booklets (daily care records) last a month, some last three to four months. They get returned when they are full". This meant the system in place for returning care records for audit did not enable the registered manager and provider to identify and act on concerns in a responsive manner. For example, the registered manager and provider had not identified that a member of staff had recorded but not acted upon one person's unexplained bruising that had occurred 28 days before our inspection.

We were not provided with evidence to show that people's medication administration records (MAR's) were checked to ensure medicines were administered safely. Not having an effective system in place to assess and monitor medicines administration meant the registered manager and provider had not identified or acted upon the unsafe medicines management practice that we identified. For example, one person was at risk of receiving too much of their prescribed pain medicine within the recommended time period because their morning and lunch calls were planned too closely together. This placed people at risk of harm to their health, safety and wellbeing.

An effective system was not in place to enable the registered manager and provider to check that people's care was being delivered at a time that met their agreed needs and preferences. Daily care record audits did not monitor people's call times to ensure staff had visited people at the agreed times and for the right amount of time. The provider told us they monitored late calls through technology that alerted them to a care call being 45 minutes late or over. However, this was a high threshold for the monitoring of late calls. Therefore, the registered manager and provider were not routinely alerted to late calls that were less than 45 minutes late. During the inspection, the provider requested a report from the company who they contracted their technology from, to identify the number of calls that were 30 minutes late or over. This showed that this information had not been routinely requested to enable the registered manager and provider to monitor late calls. If this information had been routinely requested, this evidence would have been readily available for us to view and the registered manager should have been aware of the numbers of early and late calls and have acted upon this to ensure people received their care in accordance with their agreed needs and care preferences.

Staff rotas showed that call cramming was taking place. This meant that staff rotas were not being planned

in a safe, effective, caring and responsive manner that protected people from the risks associated with not receiving their care at their agreed time.

Staff told us and records showed that they received regular supervision and spot checks to assess and monitor their performance and development needs. However, these checks had not been effective in identifying the staffs' knowledge and skills gaps. For example, one staff member had a lack of understanding of safeguarding and mental capacity. However, this had not been identified through supervision and spot checks. This meant the registered manager and provider had not identified the gaps in some of the staff's knowledge and skills gaps, that placed people at risk of harm.

The above evidence shows that effective systems were not in place to assess, monitor and improve the quality of care at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their representatives told us the registered manager and provider were approachable. The provider told us they planned to seek feedback from people using a satisfaction questionnaire later this year. This showed they planned to involve people in the assessment and monitoring of the quality of care. We will check that this has been effectively implemented at our next inspection.

Staff told us they felt supported by the registered manager and provider. One staff member said, "The manager and boss are nice". Another staff member said, "I like the manager, she has a good relationship with all the clients". All the staff we spoke with said they enjoyed working at Alpha Home Assist Limited.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems were not in place to ensure people received their care in a safe manner.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the quality of care at the service.