Personal Assistant Care Agency Ltd (PACA)

Personal Assistant Care Agency Ltd

Inspection report

Unit 13
Hampton Park West
Melksham
SN12 6LH

Tel: 01225701827

Date of inspection visit:
20 December 2018

Date of publication:
27 February 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an announced inspection at Personal Assistant Care Agency Ltd. On 20 December 2018. We gave the service 24 hours' notice that we would be visiting. This was because the location provides domiciliary care services and we wanted to make sure someone would be available to support our inspection. This was the first inspection for the service at their new registered address.

Personal Assistance Care Agency Ltd. is a domiciliary care service registered to provide personal care to people living in their own homes. Not everyone using Personal Assistant Care Agency Ltd. receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection, 20 people were using the service.

A registered manager was in post. 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.

Medicines were managed safely but some administration records required more detail, such as prescription guidance. People were protected from the risks associated with infection control.

Risk assessments were in place for people's home environments. Not all personal risk assessments were in place although staff knew how to support people appropriately and safely.

There were sufficient numbers of suitable staff on duty to meet people's needs and staff benefited from one to one supervision support from their manager.

Staff were knowledgeable about their responsibilities to report any concerns and knew how to identify abuse and what to do about it.

Although staff were knowledgeable about the Mental Capacity Act (2005), there were no recorded mental capacity assessments where there were doubts about people's capacity.

Staff training was behind schedule and most required refreshers. New staff followed an induction process which was aligned to the Care Certificate.

People's choices and preferences were detailed in their support plans. People and their relatives had been involved in developing and reviewing the plans. People were supported to attend activities, day services and maintain hobbies and interests.

The service worked collaboratively with health and social care professionals to develop appropriate support

plans and make changes when required. Staff followed guidance given by specialists to support people using best practice methods.

Feedback received from people, their relatives, and visiting professionals was very positive about how caring the service was. Staff promoted people's privacy and dignity and were respectful in their approach and methods.

The service was developing new ways of recording and documenting care plans, daily records and people's care information. This was in the early stages of implementation. This meant that not all records were organised or up to date. However, a new service manager was being recruited. They would work alongside the registered manager and take over the day to day running 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?

Good

The service was safe.

Medicines were managed safely, but recordings required more detail from the prescribed guidance.

Environmental risks were assessed and hazards identified, but not all individual risks for personal safety were in place.

Systems were in place to help keep people safe from abuse.

Is the service effective?

Requires Improvement

The service was mostly effective.

Staff were knowledgeable about the Mental Capacity Act (2005) but there were no recorded mental capacity assessments in people's support plans.

Staff training was behind schedule, but staff were aware of people's specific needs and how to support them.

Support plans were developed following assessment and guidance from health and social care professionals.

Is the service caring?

Good

The service was caring.

Support was delivered in a way that maximised people's independence.

Staff provided support that maintained people's dignity and privacy.

People, their relatives and professionals told us the staff were very caring and respectful.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in the development of their support plans.

Staff were provided with information and guidance on how to support people to meet their needs.

There was a complaints procedure in place, but the service had not received any complaints.

Is the service well-led?

Requires Improvement

The service was mostly well led.

The systems in place did not comprehensively audit and monitor the quality of the service.

Recording and documentation was inconsistent and required more robust organisation and reviewing.

New electronic systems were being implemented but required time to embed to ensure sustainability.

There was a registered manager in post who promoted the values of staff consistency and person-centred care.

Personal Assistant Care Agency Ltd

Detailed findings

Background to this inspection

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

The inspection took place on 20 December 2018 and was announced. This was because the location provides domiciliary care services. We wanted to make sure the manager would be available to support our inspection, or someone who could act on their behalf. The inspection was carried out by one inspector.

Before we visited we reviewed the information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

We spoke with two people, three members of staff and the registered manager. We requested and received feedback from two professionals who work alongside the service. We reviewed five people's care and support records, three staff personnel files and other records relating to the monitoring and management of the service.

Good

Is the service safe?

Our findings

Staff were knowledgeable about their responsibilities to report any concerns and protect people from abuse. One staff member told us, "If I have any concerns or issues regarding any clients, I escalate to [the manager] I make the phone call to Wiltshire Council." Staff were also knowledgeable about whistleblowing procedures. Whistleblowing is the term used when a worker passes on information concerning wrongdoing. Whistleblowing procedures ensure that the whistle blower is protected from reprisals when they raise concerns of misconduct witnessed at work. The service had systems and procedures in place to record all incidents and guidance for staff was on display in the office. Staff were invited and attended safeguarding meetings relating to the person they were supporting, to aid and learn from the process.

People had risk assessments completed regarding their home environment, such as identifying hazards on the stairs, lighting and kitchen chemicals. The risk assessments included actions to be taken. People had 'grab sheets' containing important information for the emergency services. These included medicines and names of doctor and next of kin. However, not all individual risk assessments were in place or up to date. One person had a moving and handling plan which had been devised by the occupational therapist, giving guidance to staff on how to mobilise the person safely. It included instructions for the service to develop their own risk assessment, which had not been completed. Although up to date information on these risks was not included in a formal risk management plan, staff we spoke with demonstrated a good understanding of people's needs and how to support them.

The service had introduced a new human resources system to manage recruitment. We noticed on this system, that not everyone had a recorded DBS check. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. The registered manager assured us that everyone went through this process and this was a recording error. Other pre-employment checks were completed including references and identity checks. The service was in the process of recruiting new staff and the manager told us, "We have enough staff but we would like two more, we don't use agency and we have always been lucky that we keep our staff for several years." Staff benefited from supervision usually on a six-weekly basis but the manager told us they were behind schedule at present. Supervision consisted of discussing performance, what was going well, development and training needs.

All medicines were administered from pre-filled dosette boxes from the pharmacy. Some people managed their own medicines and care plans listed people's medicines and when they were to be administered. Medicines administration records (MAR) were completed correctly, but some of them required more accurate information. For one person, information from the prescription had not been written onto the MAR sheet. The MAR was crossed (not administered) on some days. There were no recorded details on how often and when this medicine needed to be administered on the MAR. This meant it was not clear if the medicine had not been administered or was not due to be administered.

People were protected from the risks of infection. Staff told us they had training in infection control practices and access to personal protective equipment (PPE) supplies in the office.

Incidents and accidents were recorded. One person had an unwitnessed fall in their bathroom and had sustained a cut to their forehead. Staff had completed a body map and a detailed description of the wound and the circumstances of the incident. They liaised with the person and their family who decided not to contact the health services, preferring to treat the injury themselves. Another person who had regular seizures, fell and an incident report was completed. The person was wearing protective head equipment. The service was looking at the side effects of their medicines and a review had been requested with the health practitioners.

Requires Improvement

Is the service effective?

Our findings

Staff had received training but required refresher training as many areas were out of date, (completion dates ranged from 2015 to 2017). The registered manager told us that a schedule of refresher training with an on-line education company was to begin in January 2019. The training scheduled included dementia awareness, first aid and safeguarding. Some staff had been supported to complete their NVQ qualifications and other staff had specialist training in areas such as stoma care and epilepsy awareness.

New staff followed an induction which included areas aligned to the care certificate. These were the role of the health and social care worker, equality and inclusion and person-centred care. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of 15 minimum standards that should be covered if you are 'new to care' and should form part of a robust induction programme.

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

We checked whether the service was working within the principles of the MCA. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). In people's own homes this is an order from the Court of Protection. No-one using the service was subject to a DoLS at the time of the inspection.

We saw that people, where able, had signed a 'consent to share' authorisation. This also gave guidance on the general data protection regulations (GDPR). We saw a copy of a registered lasting power of attorney for health and welfare and finance and property for one person. However, not all legal authorisations for people were in place. The registered manager had requested these from relatives.

There were no recorded mental capacity assessments or best interest decision documentation in the care plans we reviewed, where there were doubts around people's capacity. For example, the service had doubts about one person's ability to make some decisions but accepted the decision made by their family member (who did not have legal authorisation) to make decisions for them. Another person's relative had signed a consent for GDPR but they only had legal authorisation as an appointee for finances. This person had a recently appointed independent mental capacity advocate (IMCA) to support them in making such decisions.

Staff we spoke with could tell us about the mental capacity act and what it meant in practice. For example, one member of staff told us, "Has the person got capacity at that time about that decision, if not we want a best interest's decision. We always talk to the social worker, family or doctor." However, a professional we spoke with felt that, "there are areas the team can develop their skills and knowledge, particularly around

Mental Capacity legislation and Best Interest processes in practice."

We recommend the service seeks guidance from a reputable source regarding the mental capacity act legislation and practice guidance. We also recommend that the service carry out their own mental capacity assessments where they have doubts about people's capacity to make decisions.

People's needs were assessed prior to them receiving care. We saw comprehensive assessments from health and social care professionals from which care plans were developed. Examples included input from occupational and physiotherapists, psychiatrists and chiropractors. The professionals we contacted told us that staff demonstrated a good understanding of people's care needs and support was provided according to their guidance.

People's choices and preferences formed part of their care plan and their routines were documented. Care plans detailed amongst others, 'my mornings', 'my afternoon's' which stated how the person liked to be supported. We saw in one person's care plan their personal care was very detailed. For example, it stated, '[person] likes someone behind her supporting her back', '[person] likes to be told what you are going to do' and '[person] likes to have a bath and her hair washed in the evening'. Daily notes also showed where people's likes were supported. For example, 'person had make up on, perfume and hair combed. Curtains and blinds open'. This meant that care plans were person centred and recorded individualised preferences.

We saw that care plans also contained information relating to people's dietary requirements. For example, one care plan detailed that the person had an intolerance to certain fruits and flavourings. It also detailed the foods the person liked to eat. People were supported to go shopping to choose their own groceries. All care plans detailed people's nutritional needs and preferences. One person needed their food cut up into small pieces and always had drinks with a straw. Daily records showed where people had been encouraged to eat and drink. However, there were no monitoring charts to show where people had eaten and drunk sufficiently, particularly for one person who was often not eating well.

There was evidence in care plans to show that the service collaborated with health and social care professionals to develop care plans which met people's needs. Two people had detailed moving and handling plans devised by adult social care occupational therapists, with photographed directions to guide staff. One person had specific information from a chiropractor and a recommendation that they receive treatment at regular intervals. People were supported to attend their GP and medical appointments. The registered manager told us, "We have very good relationships with community services such as nurses and GP's."

Good

Is the service caring?

Our findings

People told us the service was caring. One person told us, "They are the best care agency I have ever had" and "They are very understanding and are there to help you". A relative we spoke with commented, "The level of care is excellent."

The service promoted person centred care and the registered manager was a strong advocate of this. They told us, "all care packages are tailor made exactly for that person, it is their home and care is how they want it" and "We are good at tweaking care plans to ensure person centred care, dignity and individuality."

Recordings in daily notes were written using respectful language. This included, 'had a nice chat and tried to calm [person] down as [they were] talking very negatively'. People and relatives also told us that people were spoken to in a respectful and kind manner. One person commented, "They are very professional and always talk to me." We heard kind and patient telephone conversations between the office staff, people and relatives.

The registered manager undertook spot checks of staff practice. We saw that working practices and current performance were discussed in one to one meetings. Comments regarding one staff member included, 'good communication skills with staff and clients', 'an excellent work ethic' and 'goes that extra mile meeting the client's individual needs'. Another staff member was 'very patient and considerate' and 'has an excellent relationship with clients and families'. The registered manager was complimentary about the caring quality of their staff, saying, "I'm so proud of my team and I couldn't do it without them. They all go over and above what they are asked to do."

The service had received numerous compliment and thank you cards from satisfied people and their relatives. Comments included, "Thank you for all the care your staff gave to my mum, during the time she needed it", "Just to thank you and all the staff who have kindly helped me over the last two weeks. I really do appreciate everyone's help" and "I would like to thank you and your colleagues for all their efforts with [person] during the last months of [their] life, it was very much appreciated by [them] and myself."

Staff spoke highly of their role, one staff member commented, "The service that we provide overall is excellent. We do as much as we can for clients to remain living at home. I enjoy working for this company." Professionals we contacted told us, "The team demonstrate a caring approach and offer flexibility to the individual's family" and "The staff all know the client well and are concerned about her wellbeing and safety. They work hard to maximize the client's quality of life."

Care plans contained important information about the person. These included, what they liked and didn't like, what they could do for themselves independently and what areas they needed support with. People's social and personal histories were recorded as well as important relationships. Support was provided to maintain these relationships and to follow their individual lifestyle as much as possible.

Care plans contained guidance on how to promote and support people's privacy and dignity . People were

introduced to their support worker prior to care commencing. The registered manager told us, "I go out and meet all new clients, I get a feel of what they want then I introduce their personal assistant or support worker, at no point do they receive care without having met a member of staff first."

Good

Is the service responsive?

Our findings

People were supported to attend groups and clubs and take part in the activities they enjoyed. People's care plans timetabled when direct support was provided and when the person was enabled to attend activities. For example, one person had a recent increase from one to two staff to support them to use a transport service to get to their day services. People's preferences for home based activities were also written into their care plans. One person enjoyed colouring and knitting as well as watching TV and cooking when they were able. Another person's care plan gave guidance to staff to maximise the person's wellbeing by engaging them in activities such as wheelchair dancing and skittles.

We saw one person had a 'meaningful engagement and sensory processing' profile devised by occupational therapists in the learning disabilities service. This gave guidance to staff to enhance the person's experience around them by use of sensory stimuli. For example, feeling different textures, smelling different scents and listening to environmental sounds. A twenty-four-hour activity plan enabled staff to provide appropriate levels of activity alongside rest periods. The specialist guidance recommended, 'a little and often approach…to allow for health and wellbeing benefits to occur and reduce the risk of fatigue or harm.'

We heard a conversation between a staff member and a person's social worker and GP, updating them on the person's changing needs. This person's needs were deteriorating daily and the service was quick to identify they required further support such as respite care in a nursing home. Staff were 'chasing' the respite arrangements and successfully arranged this during the inspection.

The service was trialling an encrypted messaging service to aid instant communication between the staff group about the people they were supporting. The registered manager told us, "If something needs to be communicated it can be picked up straight away, it's better communication, we use only initials not names and only [the management team] can add people to the group."

When planning staff rosters, the software would send an alert if there were unallocated visits. This minimised the risk of missed visits. Rotas were emailed to people so they knew who was coming to support them. People could contact the service until 9pm, thereafter the office phones were diverted to whoever was on call.

The service was improving their recorded care planning methods by introducing an electronic system. This was a work in progress and as such, most care plans were in various stages of development and completion. The registered manager told us that they would make this a priority and ensure that the electronic care planning system was up to date.

One person's care plan had diagrams of facial emotions to aid communication and daily notes showed these were used by staff. Another person with limited physical abilities had a comprehensive sensory care plan which showed staff how to connect and communicate with them through their senses. This meant that the service was compliant with the accessible information standard for this person. 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.

The service had a complaints policy in place. The registered manager told us, "We have never had any complaints because we carry out random spot checks and talk to the client and gain feedback on any issues."

People's religious needs and end of life wishes were identified in their support plans. Where appropriate, people had treatment and escalation plans in place in their care plans. Some staff had received training in palliative care from the local hospice. No one at the service was receiving end of life care at the time of the inspection.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager's values for the service were clear and fed through to the whole staff group. These were primarily, person centred care and consistency of staff. A relative we spoke with confirmed these values were in place. They spoke highly of the service and how consistency of staff had been a great support to their relative and had helped them to remain living at home.

The service was in the process of changing over to an electronic method of recording. This meant that the care plans were in a stage of change and development. Some were not updated and we were told that, "Care plans were a work in progress." The service was working towards making sure the electronic and paper versions of care plans were identical but this had not been fully completed. The registered manager told us that when the systems were in full use they would be able to match up people and support workers according to skills and interests. They said it would also make the monitoring of the quality of care efficient.

The registered manager told us they liked to check and add all daily notes and MAR sheets to their electronic care planning system, on a monthly basis. However, there was no overall system of auditing the quality and performance of the various areas of service provision. The registered manager told us this was done mostly as an 'ad hoc' process and through spot checks. Care plans and records were disorganised and it was not easy to find relevant important information relating to the management of the service. This meant actions to identify the quality of recording and documenting of information was not taken to improve records in a timely manner.

The registered manager told us they wanted the service to remain small in order to provide the person-centred care and continuity of staff, which they strongly believed in. They were making improvements to the management structure of the service and were recruiting a service manager. The service manager would be responsible for the day to day running and organisation of the service.

The service sought feedback from people, relatives and staff. They used a national domiciliary care review service and produced a survey four times a year. However, the feedback surveys we saw in the service's records were inconsistently dated so it was not clear when these were completed. Staff surveys were also completed inconsistently with only a few staff members participating. Staff meetings were held every couple of months and there was an 'open door' policy where staff could discuss any issues they had.

The service had a detailed sheet of community services for people to access. This was included in people's care folders for information and covered East, West and North Wiltshire. The service is a member of Wiltshire Centre for Independent Living and have signed up to the Carers Charter. The service is also a member of the Wiltshire Care Partnership which enables them to receive peer support and share good practice.