Astha Limited

Astha Limited - Leeds

Inspection report

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Date of inspection visit:
18 April 2018
26 April 2018

Date of publication:
12 June 2018

Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

The inspection took place on 18 and 26 April 2018, and was announced. At the last inspection in November 2016, we rated the service as requires improvement. We also found the service was in breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act (2008) Regulated Activities (Regulations 2014). At this inspection we found the service had made the required improvements, but we identified further areas of improvement at this inspection.

Astha Limited - Leeds is a domiciliary care agency. It is registered to provide personal care to people living in their own houses and flats in the community. The service primarily provides care for people from the Punjabi community. All staff had a knowledge of the specific cultural and religious needs of the Punjabi community and spoke Punjabi as well as English. The service was also able to provide care for people from different backgrounds as well. At the time of our inspection the service was providing services to 13 people. It provides a service to older adults and younger disabled adults.

Not everyone using the service receives 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.

There was a registered manager in post at the time of the 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.

People told us they felt safe. There were enough staff to meet people's needs safely, and we found staff had been recruited safely. People told us staff were generally on time and communicative if they were delayed.

Medicines were managed safely overall. Staff were trained and provided clear guidance on how to administer different medicines. People told us medicines delivery was safe. However, the recording of self-administered medicines and why medicines were not administered were not always clear.

We have made a recommendation about the management of medicines records.

Risks to people were appropriately assessed and risk assessments were relevant to people's environment and needs. Staff reduced the risk of infection by using personal protective equipment.

People told us staff were trained to meet their care needs, and staff were supported by the service through effective induction, training, supervision and appraisal.

People told us staff were kind, caring and compassionate. Staff told us how they respected people's privacy and dignity, and the service demonstrated how it promoted people's independence through its guidance for

staff.

Care plans were written in a person centred way, with detailed guidelines for staff on how to care for people in a way they wanted to be cared for. Care plans were regularly reviewed or in response to a change in circumstances such as a deterioration of mobility.

People knew how to raise complaints through the service's complaints policy and procedures. People told us that where they had raised issues, they were satisfied with the service's response.

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 always safe.

Medicines administration was safe, however systems around medicines records were not always clear.

Staff were recruited safely and there were enough staff to meet people's care needs.

Staff received training in safeguarding vulnerable adults, and there was a robust safeguarding policy and procedure in place to protect people.

Risks to people were assessed appropriately and there was guidance for staff on how to reduce them. Staff helped prevent infection by using personal protective equipment such as disposable gloves and aprons.

Is the service effective?

Good

The service was effective.

People told us staff were competent and trained to meet their care needs. Staff were given adequate support by the service in the form of an induction, supervisions and annual appraisals.

People were supported to maintain healthy lifestyles by eating and drinking enough of the food they preferred. Staff communicated well with health professionals if changes in people's health was observed.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were kind, caring and compassionate.

Staff were able to describe how they protected people's privacy and dignity when delivering care.

Staff were encouraged to help people maintain their

independence and people told us this was important to them.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and contained detailed guidelines for staff on how to care for people in a way they wanted.

People knew how to raise complaints, and any issues raised were investigated appropriately.

People were supported to maintain active social lives with support from staff.

Is the service well-led?

Good

The service was well led.

There was a registered manager in post, and staff told us they were confident in the leadership of the service.

Quality assurance processes were in place which included audits and reviews. They were effective in identifying issues with performance and service quality, and we saw evidence action was taken as a result.

The service proactively engaged with people who used the service and staff members in order to drive improvement.

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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 checked 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.

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 18 April 2018 and ended on 26 April 2018. We visited the office location on 18 and 26 April 2018 to see the manager and office staff; and to review care records and policies and procedures.

The inspection was conducted by two inspectors. The service provides care for people mainly from the Punjabi community, and one of our inspectors was skilled in speaking Punjabi to ensure we could gather accurate feedback from people who use the service. We spoke to three people who use the service and three relatives of people who use the service by telephone. We also spoke with five staff, including the registered manager, care coordinator and care assistants. We also gathered evidence prior to our inspection; this included statutory notifications sent to us by the provider.

We reviewed six people's care plans as well as other documents relevant to peoples care. For example, six people's medicine administration records, the service's complaints log and six staff recruitment files.

Requires Improvement

Is the service safe?

Our findings

We reviewed medicines management at the service. We found that medicine administration records (MARs) did not clearly indicate whether the person had self-administered their medicine and/or another agency had assisted.

For example, by looking at one person's accompanying medicines care plan, it was clear that the person was occasionally given their medicine by family members because it was stated that either staff or family members were to support the person, and the service's medicines policy states that they should indicate whether this had happened in the MAR using a designated code instead of a staff signature. However, in another person's care plan, this information was not present; therefore the records were unable to show why that code had been used and the medicine not administered by the member of staff. The registered manager informed us the person did sometimes take their own medicine and were looking to have medicines administration removed from their care package because they were able to do so themselves.

One person's MARs we looked at did not clearly show why their medicines were not given. For example, the same code was used to indicate gaps between doses of their weekly transdermal medication patch. It was unclear from the documentation why the code had been used because this information was not in the person's medicines care plan. The person did not self-administer, and the registered manager confirmed medicine was not given in between prescribed doses, and that this was a recording issue.

We therefore recommend the provider review it's MAR documentation and provides support for staff in clarifying their use.

Other elements of medicines administration were safe. Staff had received training on medicines administration and we saw evidence they had received bi-annual competency checks conducted by the registered manager. This included observed practice to make sure staff were following the medicines policy and administering medicines safely. People and their relatives told us they received their medicines safely and that they had no concerns with staff competence or practice. One person said, "I'm not concerned about staff training and supervision. They give me medicines from the dossett box and I feel safe." MARs contained good personalised information and guidance for staff on each type of medicine, dose, and any possible side effects for that person. Where people refused to take their medicine this was recorded clearly with reasons and actions taken. For example, we saw staff record a person had refused to take a medicine because they were agitated. The staff member reported this to the registered manager and family who then contacted their GP.

People and their relatives told us the service was safe. One person said, "I feel my mother is safe. Any instructions they (staff) take on board." Another relative said, "I was at my mum's house a lot when we started using the service, but now I feel I don't have to check and I can go away and I don't have to think about it. It is such peace of mind."

People told us there were enough staff to meet people's care needs and that staff were generally on time.

They told us that if staff were going to be late they were always informed beforehand. One relative said, "Yes there are enough staff, always two carers. Carers are generally on time, I think give or take ten minutes for traffic or bad weather, and if they are late it's never a long time. They let me know if they will be later than five minutes and say they will be on their way." Another relative said, "There are enough staff, and they are generally on time. They have my mother ready at a certain time every day and are pretty punctual. They let me know if they will be late. They had to cancel once because of the snow but communication is pretty good."

The service was able to track staff electronically through a smart phone system, and there was an on call rota so a senior member of staff was always available. We reviewed the latest data which showed that staff were able to make their calls on time and were able to stay for the duration of their call. In the 2017/18 annual survey, 95% of the 29 respondents stated staff were always on time, 4% usually on time and 1% sometimes.

We reviewed staff files and found staff were recruited safely. Files included completed application forms, interview notes, professional and personal references, identity checks and a Disclosure and Barring Service (DBS) check. The DBS is a national agency with access to the police national database which helps employers make safer recruitment choices so that staff are safe to work with vulnerable people. There was evidence that photo ID checks had been carried out and that the service was assured all staff had the right to work in the UK before being accepted.

All staff had received training in safeguarding vulnerable adults. Staff were able to describe how they would protect people from abuse. One staff member said, "It's about keeping people fully safe, clear of hazards and protected from abuse." There was a whistleblowing policy in place which ensured staff could raise concerns anonymously. We saw evidence that the service was in regular contact with the local authority where potential concerns were identified, and that these were investigated appropriately.

At our last inspection we found that while risks were identified, there was no rationale behind the rating, and there was no guidance for staff on how to reduce these risks. At this inspection, we found that the required improvements had been made. For example, where a person who had a history of pressure sores was risk assessed, staff were guided to follow repositioning care plans, check for pressure sores and contact the person's district nurse to ensure sores did not develop and degrade. There were risk assessments in areas such as falls, equipment safety, and environmental risks around the person's home. Risk assessments were person specific. For example, where one person was having a new room constructed in their house a separate risk assessment had been written to ensure their safety whilst work was being carried out.

Staff received training in preventing infections. Staff had access to a good stock of personal protective equipment (PPE) such as gloves and disposable aprons. People we spoke with said staff were clean and always used PPE. One person said, "Yes they always have disposable gloves and wear plastic covers on their shoes. Nothing I've seen suggests concern."

The service had a business continuity plan in place to ensure people's needs could be met in the event of a significant disruption to services such as a natural disaster or loss of IT facilities.

Good

Is the service effective?

Our findings

People and their relatives told us they were confident staff were competent and well trained. One person said, "I think they know what they are doing. If there is someone who doesn't they are gone. They know exactly what they are doing." A relative said, "Well trained yes. [Name] has to be hoist lifted. The carers who come who are well trained, when I am there I observe them."

We reviewed training information and found that staff received appropriate training and support. New staff were provided with a structured induction into the service. This included meeting the manager, an introduction to people through their care plans, and undertaking 'shadowing' shifts where new staff would observe colleagues providing care. Staff also completed training considered by the service to be mandatory before working with people. This included moving and handling, safeguarding vulnerable adults, basic life support and food hygiene. Training was provided by an accredited external organisation. The service used a training matrix to identify what training staff had taken and when training was due to be refreshed for each individual staff member.

Staff were provided with regular supervisions, appraisals and spot checks so that senior staff could monitor their development and identify training needs, personal issues and any other area of support. Supervisions also included people's feedback on staff gathered by the registered manager. For example, in one staff member's supervision it was noted that, '[person name] said they enjoy [staff name's] company and refers to them as 'daughter'.

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.

The registered manager had a good understanding of the principles of the MCA, and care plans included these principles as guidelines for staff to follow. For example, where one person had a mental capacity assessment carried out for their dementia related condition, the care plan explicitly guided staff on how to ensure they supported the person under the principles of the act. Their care plan stated, 'I have the right to choose what I want to do. Do not make assumptions about my capacity. Give me the opportunity to participate in care and give me time to respond to your questions.' Where people had mental capacity assessments carried out, relevant documentation from social services was included in people's care plans and this informed care planning.

We spoke with staff about their understanding of the MCA. Some staff did not always demonstrate good understanding of the act itself, however other staff did, and all staff we spoke with were confident care plans provided appropriate guidance. We raised this with the registered manager who told us that refresher training would be provided.

People and their relatives told us they felt confident staff helped people to maintain a healthy lifestyle. On relative said, "They inform me if [Name] is ill and they would contact the GP when I was away, I left the GP's number with them. Never had to ring doctor. We have a district nurse who comes in, checks bed sores, carers keep an eye on her and apply medication as well. When nurse's come the carer helps turn her over. Carers let the nurse know if they notice anything or tell me."

Staff also supported people to maintain their wellbeing by eating and drinking enough and received training in food hygiene. Care plans contained detailed instructions on what food people liked and what choices to offer them. One relative said, "They always offer choice. Normally with food, either we make it and leave it for staff to heat and serve or they make something they like. They always make sure drinks are available."

Care plans recorded people's consent to care, and these were signed and dated by the service user or their representative. Care plans guided staff to seek consent before delivering care.

Good

Is the service caring?

Our findings

Everyone we spoke with told us staff were caring, kind and respectful. One relative said "They are always very respectful and kind, I couldn't find a fault they treat mum like their own grandmother, and talk to her with respect and care. For me to know they have the same language, it's lovely they share a joke and gossip from outside. They interact and have conversation; it's nice for me to know." A person who uses the service said, "They like coming, it's a laugh, I make them laugh and they make me laugh." Another relative said, "They still make tea for my dad as well even though he doesn't need the service. It's the little things. If the weather is nice they take mum outside if she wants to. It's extra work but they never object, they will do it." A respondent to the annual survey stated, 'Astha Care staff are good company to my mother and is punctual. Very good in prompting in Punjabi language to my mum for routine care tasks. Very caring, reliable, compassionate and efficient'. In the 2017/18 annual survey, 100% of the 29 respondents replied positively with regards to staff's caring attitude.

The service primarily employs staff who are from a Punjabi/Sikh background in order to cater to people's cultural and religious needs that they might not receive from another provider. For example, knowledge of traditional Indian dress, languages and food. People and their relatives told us the service met their cultural needs successfully and that this made a positive impact on their lives. One relative said, "My mother is Punjabi, all the staff speak Punjabi and are able to pick things up very quickly.

The service was able to provide for people from other backgrounds. We spoke to people from other communities who told us they always felt respected by staff. Documents we looked at recorded people's cultural and religious preferences in detail. For example, to use a specific language or specific cultural greeting, or to prepare a vegetarian diet in accordance with their religious beliefs. This included reminders for staff to speak in English. This meant the service was operating under the principles of the Equality Act (2010).

People's privacy and dignity was maintained by staff who were not afraid to challenge behaviour that might compromise this. For example, we saw records where staff had spoken to the registered manager about family members interrupting a person receiving personal care as this affected their privacy and dignity. The registered manager had held a meeting with family members and agreed that they would not interrupt staff when delivering personal care. In the 2017/18 annual survey, 100% of the 29 respondents indicated that their privacy and dignity was respected. One staff member we spoke with said, "It's about keeping things confidential and keeping doors and curtains closed when people are getting changed for example."

The service promoted independence through people's care plans. Care plans included what outcomes people wanted to achieve, and we found many of these were centred around maintaining their independence, for example, 'To be as independent as possible' and 'Build confidence and helping me to improve mobility'. One staff member we spoke with said, "We always communicate with people and offer them choices, for example if they want to help making food."

Good

Is the service responsive?

Our findings

People were assessed appropriately by the manager before using the service to make sure the service was able to meet people's care needs. This included recording key personal information, specialised equipment people used such as hoists and wheelchairs, medical histories and the person's important social or family links.

Care records we reviewed were person centred, and provided staff with detailed and clear guidelines to care for people in a way they wanted. One care plan instructed staff to introduce themselves with a traditional Punjabi greeting and that the person wanted to be addressed by a preferred name. Care plans contained information important to people, such as their life history, hobbies and interests, and family members who were important to them. Care plans contained a list of tasks to be completed at each visit, but also guided staff to offer people choices about their care. One person we spoke with said, "I am always asked for choice and staff are very friendly. They do not let me struggle and do as I ask." One care plan read, '[Name] has capacity and understands their condition, they are able to make their own choices.' Another care plan read, '[Name] likes porridge and warm milk. Always ask them to choose what they wants to eat' and, 'Help me to wear clothes of my choice.'

Care plans were reviewed on a regular basis with involvement from people and their loved ones. Care plans were also reviewed and updated to reflect changes in people's circumstances, such as visits to hospital and deteriorating health. One care plan we looked at was reviewed in partnership with the person and their family with the outcome that more care hours were needed due to a professionally assessed deterioration in the person's mobility.

The service supported people to maintain active social lives. Care plans guided staff to understand people's social needs. For example, one care plan read, 'I like to chat a lot and am sociable; I have strong attachment to my Punjabi culture and family support.' Staff were instructed to help people wash and dress in time for routine social appointments such as day centres and religious services, and often accompanied people in order to facilitate this. Care plans recorded people's hobbies and interests and these were taken into account, for example one care plan instructed staff to help a person watch their favourite religious programmes when they wanted.

Complaints were investigated appropriately and followed the service's policy. There had been four complaints since January 2017, and all of them had been responded to in a timely and courteous manner. All complaints were resolved to the satisfaction of people and their relatives. People we spoke with were confident they knew how to raise a complaint. One relative said, "I know the process. There was something little I raised and they dealt with it, they put in extra training and I was pleased with the response."

Service user welcome packs sent by the service provided information on how to complain, blank complaint forms, and information about other agencies including CQC if they were dissatisfied with their outcome.

The service had the facilities to provide information in a variety of formats such as large print and languages

other than English. Communication of information was discussed and people's preferences recorded as to how they wanted to receive information.

Good

Is the service well-led?

Our findings

People we spoke with were confident the service was well-led. One person said, "If we have any queries we go to the manager. The registered manager is our contact. The care coordinator as well, they are easy to get a hold of." Everyone we spoke with told us they would recommend the service. One relative told us that they had recently told their friends about the service and recommended it to them.

There was a registered manager in post at the time of the inspection. The registered manager sent monthly reports to the provider regarding care plan reviews, finances, any incidents that had occurred and feedback from surveys and questionnaires. They also met face to face on alternate months with the director. The registered manager told us they felt well supported by the provider, saying, "We have daily phone calls. I report regularly to the director and project manager."

We reviewed the service's quality assurance processes which comprised a series of audits and checks. The service conducted monthly MARs audits, taking a sample and ensuring each person had at least one MAR logbook audited every six months. We saw evidence that issues were identified and that the registered manager took action to address these with staff. For example, in one audit it was identified that a staff member had not recorded whether they had prompted a person to take their medicine or they had refused, and a supervision had been arranged for that staff member.

The registered manager and the provider also conducted audits of daily notes or 'log books'. We saw evidence these had been used to drive improvement. For example, one audit reviewed a number of log books where staff had used informal or non-standard English terminology when describing tasks. The registered manager said this was linked to staff who did not speak English as a first language, and could lead to confusion about what tasks had been completed. As a result, the service introduced a new style of logbook which indicated the tasks completed with space for staff to report other aspects of people's care.

Staff we spoke with told us they felt well supported by the registered manager. One staff member said, "I feel supported and am comfortable talking about shifts and any other issues." The service conducted regular bi-monthly staff meetings which were well attended. We looked at the minutes of the last staff meeting held in January 2018. Topics discussed included information about a new staff member, relevant changes to people's health and care needs, potential new care packages, a reminder to use the electronic sign-in system, PPE use and coordinating annual leave for staff.

The service did not conduct analysis of incidents or complaints for trends and themes because these were so infrequent that they could be analysed on a case-by-case basis. The service also analysed written and phone call feedback annually. Of the 29 responses between January 2017 and February 2018, feedback was universally positive. Comments where people made suggestions about further improving the service were fed back to the registered manager. For example, one person stated they wanted the same carers to come on their shifts, and the registered manager communicated with them to discuss rotas and staff availability. We concluded the service's systems around quality assurance were sufficiently robust.

People were proactively engaged by the service so that their feedback could be used to drive improvement. People told us they received questionnaires about the service and had also received frequent spot check visits by the registered manager or the care coordinator. One relative said, "Yes, I've received questionnaires. They also come out and see you. They are very accommodating." One person told us, "They do spot checks regularly. The manager pops in without letting carers know. Sometimes they send me a form to fill in to say if I am happy with the service so I fill that in." We saw in January 2018 that 18 spot checks had been carried out. During spot checks, people were asked if staff followed their care plans, if they were flexible, if they were happy with staff and if they had any complaints. All people asked provided positive feedback.

The registered manager understood their obligation to submit notifications to CQC of serious incidents such as deaths, serious injuries, police investigations and changes to their registration. We found they submitted notifications correctly and in a timely way.