Alina Homecare Ltd

Alina Homecare Walton on Thames

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

We carried out this announced inspection on 30 May 2018. This was the first inspection of this service since it registered in February 2017.

Alina Homecare is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older people and people with physical disabilities.

Not everyone using this 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 consider any wider social care provided. At the time of our inspection the service was providing personal care to 29 people.

The service had a registered manager who had been post since the service had registered. 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 that their care workers were respectful and kind and praised the quality of the service. People were able to contact the office when they had concerns and were regularly contacted to ensure that they were happy with their care. The provider had assessed people's communication needs to make sure they were able to speak up. There was a clear process for responding to complaints and concerns and ensuring that these were resolved.

The provider operated safer recruitment processes to ensure that staff were suitable for their roles. When people required two care workers to support them this was taking place. Electronic call monitoring was used to ensure that punctuality was maintained. People told us that care workers arrived on time. Care workers received appropriate training and supervision to carry out their roles.

Risks to people's health and wellbeing were assessed and appropriate plans were in place to mitigate this, including safer moving and handling procedures. Staff were able to recognise signs of abuse and follow the provider's policy to safeguard people from abuse. People's medicines were safely managed and this was routinely audited by managers to make sure people received the right medicines. There were systems in place for monitoring incidents and action was taken in order to reduce the risk of a recurrence.

People had consented to their care, and when people lacked the capacity to do this, the provider had assessed people's capacity to make decisions. However, it was not always clear when a person's relative had signed for their care why this was happening. We have made a recommendation about this. People's nutritional needs were assessed and care workers shared good practice around how they could meet these.

Managers had systems in place to check the quality of the service and had a clear vision for what good performance should be. Good communication was maintained between managers and care workers, and people using the service told us they found it easy to contact managers and saw them regularly.

People's care was planned in a way which met their needs and preferences. People received care in line with their plans and these were regularly reviewed. People spoke of when the service had responded to help them in an emergency.

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.

Measures were in place to ensure that people were safeguarded from abuse and that risks to people were fully assessed.

The provider operated safer recruitment measures to ensure that staff were suitable for their roles. Staffing levels were suitable to meet people's needs and punctuality and attendance were monitored through call monitoring systems.

Medicines were safely managed and audited by managers.

Is the service effective?

Good

The service was effective.

Care workers received suitable training and supervision to ensure they had the right skills for their jobs. People's needs were comprehensively assessed before they started to use the service, including those relating to health and nutrition.

Consent to care was obtained and people's capacity to make decisions was assessed. It some cases it was not clear why relatives had signed on people's behalf.

Is the service caring?

Good

The service was caring.

People told us they were treated with kindness and respect by their care workers.

There was information on how people communicated and the provider made regular calls to people to obtain their views on their care.

Care plans contained detailed information on what was important to people and how best to promote independence.

Is the service responsive?

Good

The service was responsive.

We saw examples of when the provider had adapted when people's needs had changed.

People's care was clearly planned and records showed that care was delivered in line with this. Plans were regularly reviewed to ensure that people's needs were met.

People told us they were confident approaching the provider if they had a complaint and there was a clear process for addressing these.

Is the service well-led?

Good

The service was well led.

People told us they regularly saw managers and had no difficulty contacting them. Care workers felt well supported.

There were extensive systems for checking the quality of care and identifying issues of concern.

There were measures in place to ensure good communication with care workers.

Alina Homecare Walton on Thames

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.

We carried out this inspection as we aim to inspect services providing a regulated activity within 12 months of their registration. We were not aware of any concerns about this service. The provider was given two working days' notice of this inspection. This is because the service provides care and support to people in the community; we needed to be certain that someone would be in the office.

The inspection was carried out by a single adult social care inspector. We visited the office on 30 May 2018. On the following day we made calls to people using the service and care workers. We made calls to three people who used the service, three relatives of people using the service and three care workers.

In carrying out this inspection we looked at records of care and support provided to five people and records of medicines management for four people. We looked at records of recruitment and supervision of five care workers and information relating to the management of the service, such as rotas, team meetings, training and audits. We spoke with the registered manager, quality assurance manager and two co-ordinators.

Good

Is the service safe?

Our findings

The provider had adequate systems to safeguard people from abuse and to assess and manage risks to people using the service.

The provider's safeguarding policy contained clear measures on how to prevent abuse and respond to allegations of abuse. Staff received yearly training in safeguarding adults and were clear about how they recognised signs of abuse and their responsibilities to report this. One care worker told us "If I thought for one minute that a client was in danger or their safety was not assured I'd ring the office."

The provider assessed risks to people using the service as part of their initial assessment and reviewed risk management plans regularly. These included an assessment of the hazards in the person's home, and risks from fire, falls and those relating to people's health conditions and disabilities. A relative told us "[My relative] is a falls risk, so they make sure to stay with her and to meet her needs…they are very attentive."

The provider undertook an assessment of people's needs and associated risks with moving and handling. This included outlining what people could do for themselves, how their ability may fluctuate and any equipment the person used to mobilise. We saw that when care workers were required to use a hoist to support a person to transfer they had obtained evidence that the equipment was safely maintained. There was a clear people handling plan, which outlined risks to the person, how care workers could support the person safely and how many care workers were required to do this. Where two care workers were required, we saw that this was taking place. Plans contained information on how to manage the risks of infection, including the use of personal protective equipment (PPE), and we saw care workers coming to the office to collect PPE. A relative told us "They are very keen on that."

People were assured that staff were suitable for their roles as the provider followed safer recruitment measures. This included obtaining a full work history, proof of the person's identification and right to work in the UK before they started work, and carrying out a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.

The provider's policy stated that they would obtain two references before the person started work, which was taking place. However, the provider's policy was not clear about the need to obtain evidence of satisfactory conduct where a person had previously worked in health or social care roles. This meant there was a possibility staff would not know to do this if this did not refer to the person's previous job. The provider carried out audits of care worker files to make sure safer recruitment processes were followed.

People told us that care workers arrived on time. Comments included "They're quite punctual" and "If there is a long delay they always phone me, but it's not a regular thing." The provider used an electronic call monitoring (ECM) system to ensure that care workers arrived for their calls. We saw records of this system which showed that it was used appropriately by care workers. Punctuality had steadily improved since it was implemented, and now 90% of care workers arrived within 30 minutes of the planned time. Care

workers told us they received sufficient time to travel to their calls, and we confirmed this by checking staff rotas. The provider had a business continuity plan in place in the event of significant disruption. We saw that following a recent incident of severe weather, the provider had conducted a review of how this plan was implemented and taken steps to improve staff access to this.

Medicines were safely managed by care workers who had the skills to do this, and this was closely monitored by managers. The provider had assessed people's needs including whether they were able to open bottles and use compliance aids and assessed the support people required. In one instance we noted that the provider was using "prompting" to describe a situation where a person was directing their medicines with only physical assistance from care workers. The provider had detailed records of what medicines people took, what they were for and who was responsible for their administration.

Where people had medicines administered by care workers, these were recorded on suitable medicines administration recording (MAR) charts. We looked at three months of records for four people. In all cases these were fully completed by care workers, and every chart had been audited by a manager. Where there were gaps on these charts, managers had linked these to times when visits had been cancelled or the person was in hospital.

Where incidents had taken place, these were recorded by managers, with details of how an incident had occurred and what the provider had done in response. For example, where a medicine error had taken place, a care worker received additional supervision and training and a procedure was agreed with the person's family to prevent recurrence. The provider told us "Incident reports are sent to a quality mailbox and we monitor on a monthly basis to minimise the risk of repetition."

Good

Is the service effective?

Our findings

The provider carried out a detailed assessment of people's needs to ensure their care was effective. This included assessing the support people required in areas such as personal care, domestic assistance and emotional support. Assessments noted how people's abilities could vary due to factors relating to their health and how care workers could best support them with this.

Care workers were positive about the training they received. One person told us "The trainer that we had was brilliant, very explanatory. It made it feel easier. I've just had a refresher just over a year it was I think. Even on the refresher I picked up some new skills" and another said "That trainer was absolutely first class…. She was very patient, she went through it all with me. I did learn a lot from her."

Care workers underwent a detailed induction process in line with the Care Certificate. 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. The provider monitored staff training with the use of a training matrix. This showed that care workers had up to date training in key areas such as medicines, dementia, fire safety, first aid, food hygiene, moving people safely, safeguarding and person centred care.

The provider told us that care workers were expected to receive supervision on a three monthly basis. We saw that formal supervision was taking place at a lower rate than this, but the care worker records we looked at showed that they had all had a recent supervision session. Supervision was used to discuss people's working relationships with people and their relatives, give feedback on their performance, discuss any personal issues which may affect their performance and agree an action plan to develop their skills. In addition, all care workers had received a spot check, where a manager observed them providing care and made observations relating to their interaction, confidentiality, dignity and whether correct techniques were used in relation to moving and handling, infection control and medicines. Care workers told us they found these checks useful and received useful feedback from their managers.

The provider assessed people's needs around nutrition and hydration, including the support people required around food preparation, eating and drinking and accessing food and drink between visits. We saw records of a chat group, where care workers had shared examples of how they had prepared meals to make these more appetising to people who needed encouragement to eat. The registered manager told us, "it's got a bit competitive…. I think it's important, you eat with your eyes first." One person told us "They do me some nice meals".

People's health needs were assessed as part of their initial assessment. This included gathering information on people's diagnosed conditions, the possible effects of these and how staff could best support them when they became unwell. A relative told us "If they were concerned about anything like any bruising they always bring it to my attention."

The provider was obtaining consent to care in line with the Mental Capacity Act (2005) (MCA), but had not always clearly documented the reasons why people were not able to consent to care. The Act 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.

In most cases we looked at, people had signed to indicate their consent to care. Where people were not able to do so, the provider had a framework for recording whether this was due to a lack of decision making capacity or due to physically being unable to sign. Where people were not able to sign due to physical restrictions, there was a procedure for making sure that the reason why was documented and whether the person had verbally agreed to the contents of their care plan. We noted that one person's plan gave conflicting information as to whether the person had capacity to sign. However, where another person's capacity was in doubt, the provider had carried out a thorough assessment of the person's capacity. A relative had signed on their behalf, but it was not clear whether the relative had legal power to be able to do so, or whether they were indicating they agreed that care was being delivered in their best interests.

We recommend the provider take advice from a reputable source to ensure verbal consent and best interests decisions are clearly documented in line with the MCA.

Good

Is the service caring?

Our findings

People told us their care workers were caring. Comments included "They're a fantastic team", "They're very good" and "They give you 100%, my neighbours keep saying 'you've got some lovely girls looking after you'". One relative said "If [my relative] is down in the dumps, they cheer [him/her] up."

The provider sought people's views on their care and gave them the opportunity to speak up. Co-ordinators made calls to people every two months to check people were satisfied with their care. This included asking people whether their care workers were reliable, punctual and meeting their needs. People were also asked to rate their care workers for helpfulness, respectfulness and compassion, and their comments were recorded on what they were happy and unhappy with.

As part of the assessment process, the provider recorded information on what was important to people under the heading "What makes me, me." This included information on people's life stories, occupations, hobbies, religion and family backgrounds. We saw examples of detailed information on people's backgrounds and the social support they received to maintain community involvement. The provider's policies were clear about the need to protect people with any protected characteristics from discrimination, and the safeguarding policy highlighted discriminatory abuse and when people may be at risk of this.

People's communication needs were also assessed, such as the use of communication aids. Care workers and managers we spoke with were knowledgeable about how to communicate with people, such as the best time of day to speak with a person and their habits, such as when they removed their hearing aids. There was also information on how people communicated non-verbally, such as the signs that a person may not wish to interact with a member of staff that day or how they would request certain items, with clear examples for staff on how to respond to these.

Plans were also clear about how to maintain people's independence. As part of the assessment process managers had assessed what people could do for themselves, and there were detailed instructions on how to promote this. For example there were instructions on how to encourage a person to wash their own face, by explaining what was needed and passing them a flannel at a particular time. One person's plan had been revised as they regained their independence, with care visits being reduced accordingly from four visits to one visit per day.

People and their relatives told us they were treated with respect by care workers. People gave us examples of how care workers did this, for example by making sure the door was closed when giving personal care, and by putting towels around the person to maintain their dignity. This was checked during observations of care workers, and people were asked during reviews if they felt they were treated with dignity.

Good

Is the service responsive?

Our findings

People using the service gave us examples of when the service had responded to their needs. One person told us "I had a fall and [my carer] called for an ambulance. The whole company changed around their days and stayed with me until the ambulance got here. They really have raised my quality of life" Another person said, "I had an accident…they were very good." The provider told us they had recently put extra care visits in place for a person who had recently had a fall whilst they recovered. For another person, the provider had recently carried out a review due to change in their needs, and had drawn up a new care plan with the person, significantly increasing their visits in order to meet the person's needs. When a person had requested a change to their time, we observed the co-ordinator checking with social services that this was permitted before arranging this and confirming the change with the person.

People's care plans were clear and detailed about the support people needed, including the particular tasks that care workers needed to carry out on each visit. This visit plan also had information about people's routines and preferences for their care, including how they liked care to be carried out and the food and drink that they liked to be offered. There was also clear information on what was the responsibility of care workers and what families did, and how care workers could best support family members with their caring roles. Daily notes showed that people's care was delivered as planned.

The provider had systems for regularly reviewing people's care plans to make sure they still met their needs. For example, after starting to care for a person, a two week review was held in order to find out if the service was making the person's life easier, whether they were happy with their care workers and if the service had matched the person's expectations. A relative told us "[The co-ordinator] spent some time, she was here for about three days, she came and discussed it all and came along for the first few visits and to make sure all [my relative's] needs were met in the time."

The provider had a clear policy to ensure they worked in line with the Accessible Information Standard (AIS). This included guidelines on how best to assess people's needs and present information, including verbal and written communication. The AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS.

People told us they were confident making complaints to the office or raising concerns if they needed to. Most people told us they had not had cause to do so. One person told us, "It was just a silly thing, one of the young girls made a mistake. They were very helpful and it's never happened since." The provider had a complaints process, which included recording details of the complaint, action that was taken in order to investigate this and actions taken to prevent a recurrence. The process included clear timescales for responding to complaints and a requirement to call the person two weeks later in order to check there were no further problems. We found that nobody had made a complaint, but where a person had raised a concern about care, the provider had recorded this, and had held a meeting with the person and their family and agreed a clear action plan for addressing this.

Good

Is the service well-led?

Our findings

Staff told us that they received good support from their managers to carry out their roles. Comments included "I love the company, I love my job" and "[the registered manager] pushes herself over the edge to help people out even if she's busy. She always puts people first." The registered manager told us "I must admit we've got a really good team, if we can see something that can help a person they do it."

People using the service were positive about the quality of management. Comments included "There's always somebody on duty there" and "The managers come out and cover so I get to see [them]." Rotas showed that managers regularly provided care to people. There were systems in place to monitor the quality of the care people received, such as carrying out spot checks and regular telephone monitoring. One person using the service told us "They certainly come round monthly or something like that and they watch what's being done."

There were clear procedures for maintaining quality. Policies and procedures were regularly reviewed and discussed with staff, and the provider had posters which provided clear visual guides for what 'good' looked like, for example in relation to safer recruitment, customer service and customer compliance. These included measures such as always returning calls, logging details, and carrying out regular reviews of people's needs.

The provider had several layers of audit in order to assess quality. The branch manager carried out a monthly audit of the service, including looking at a sample of care plans and records, staff files, training and supervision. These were used to report back on important information such as punctuality, incidents and accidents. Care plans were audited to ensure that these were reviewed regularly and that information on these were up to date. Logs of care were routinely and comprehensively checked to ensure that these were completed correctly and that people received appropriate care. All medicines records we saw had been checked by a manager and possible issues explored.

In addition, the quality assurance manager carried out a six monthly check of the branch, but told us that this could be carried out more frequently if necessary. Key figures on performance were also monitored, such as the number of supervisions carried out, the compliance with electronic care monitoring system and punctuality of care visits. The quality assurance manager told us "We look at trends, too", and we saw that audits contained graphs showing performance over the last year, so managers could identify any areas of worsening performance.

There were good systems of communication with care workers. A bimonthly newsletter was sent out to staff to ensure they were aware of changes within the branch, reporting requirements and protocols for contacting managers.

Team meetings were used to discuss staff requirements, including areas of concern with people that needed to be reported. There was also a 'carers forum' in place, whereby care workers could meet with senior members of the organisation away from their direct management. As a result of this an online chat group

had been started up using a secure messaging protocol, so that care workers could share information directly and provide support for one another. A care worker told us "It's quite good, it's like a little walkie talkie. If someone's stuck with something we can pass on. It all seems to work out." People using the service were aware of this group. One person told us "[if there's important information] they normally put it on their chat group. I think it does help".

The provider also carried out a yearly satisfaction survey with people using the service. The previous survey was carried out in June 2017, and managers told us they were preparing to carry out a new one. This asked, for example, whether people were happy with their care and found their care workers to be reliable and respectful and was analysed by an external provider. We saw that feedback from this survey was overwhelmingly positive.