Arch Healthcare Ltd

Arch Healthcare Ltd

Inspection report

Suite 5, Tilcon House
Low Moor Lane, Scotton
Knaresborough
HG5 9JB

Tel: 07515726408

Date of inspection visit:
09 August 2018

Date of publication:
11 September 2018

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

Arch Healthcare Ltd 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 adults, younger disabled adults, and children. At the time of the inspection, there was one person using the service however, we also reviewed records of people who had previously used the service. The service registered with CQC in August 2017 and this was their first rated inspection.

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.

There were enough appropriately trained and qualified staff to meet people's needs. Staff managed people's medicines effectively, and staff were recruited in a safe way.

Risks to people were assessed appropriately, and staff demonstrated an understanding of how to protect people from abuse.

The service understood and operated under the principles of the Mental Capacity Act (2005). People's health and wellbeing was monitored and upheld. People's nutritional and hydration preferences were clearly recorded.

Interactions with healthcare professionals were clearly recorded and the service understood its role in supporting people to maintain a healthy lifestyle.

Staff received an appropriate induction, training programme and ongoing monitoring and support.

Relatives of people using the service told us staff were kind and caring. The service promoted people's dignity, privacy and independence through its documentation and in practice. People's diverse characteristics were considered and protected.

Care plans contained person-centred, holistic information and clear guidance for staff on how to care for people in the way they wanted. Care plans were regularly reviewed. The service had received no complaints since it registered, but there was a policy in place outlining how any complaints raised would be investigated and responded to.

There was a sufficiently robust quality assurance process in place. There was a clear vision for the service and its values were visibly promoted through its interview process and documentation. The service worked in conjunction with partner agencies to improve the quality of the service delivered. People and their relatives were engaged with in a positive way

The service was working under the principles of the Accessible Information Standard.

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.

There were enough staff to meet people's needs and staff were recruited safely.

Systems and processes around managing people's medicines were safe.

Staff understood how to protect vulnerable people from harm and staff had access to a large stock of personal protective equipment.

Is the service effective?

Good

The service was effective.

Staff received a comprehensive induction to the service and an ongoing programme of supervision and spot checks.

The service was working under the principles of the Mental Capacity Act (2005). People's consent to care was recorded appropriately.

People were supported to maintain a healthy lifestyle and staff knew how to meet people's nutritional needs.

Is the service caring?

Good

The service was caring.

The service responded proactively to people's protected characteristics and promoted people's privacy and dignity.

The service respected and upheld people's independence and promoted them to make decisions for themselves.

Is the service responsive?

Good

The service was responsive.

Care plans were written in a detailed, person centred way with

clear guidance for staff on how to meet their needs.

People were supported to engage in meaningful activities so that they could maintain active social lives.

Is the service well-led?

Good

The service was well-led.

There were clear values and a vision for the service going forward.

There were sufficiently robust quality assurance processes in place. The service engaged positively with partner organisations.

The service engaged proactively with people and their relatives to gather feedback.

Arch Healthcare 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 was carried out by an adult social care inspector. 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.

We visited the office location on 9 August 2018 to see the registered manager and office staff; and to review care records and policies and procedures.

We gathered and reviewed information we held about the service prior to inspection. This included statutory notifications (notifications about events or changes the service is legally obliged to provide), feedback from the local authority and any feedback we had received from members of the public.
We did not ask the service to send us a provider information return (PIR). The PIR is a document we ask providers to send to us giving information about the service, what it does well and how it intends to make improvements.

During the inspection we spoke with the registered manager, who also provided care. We spoke with a relative of someone who used the service by telephone to gather their opinion of the service. We looked at two care plans and other documents related to people's care, such as risk assessments and medicines administration records. We also reviewed other documentation relevant to the operation of the service, including training records and audits.

Good

Is the service safe?

Our findings

We spoke to a relative who told us the service was safe. They said, "No concerns, they are very good, excellent. [Name] is always safe."

There were enough staff to meet people's needs. The service used an electronic rota system which also sent relevant handover information about people prior to their shift beginning. A relative we spoke with confirmed staff were always on time. Personnel files included a detailed and extensive interview process linked to care standards. The provider sought references, evidence of relevant qualifications and verified people's identity. The service also conducted a disclosure and barring service (DBS) check. The DBS is a national agency that uses the police national database to help employers make safer recruitment choices to protect vulnerable people. We saw one instance where the service had used information from it's checks to withdraw a provisional employment offer to a prospective staff member, in order to safeguard people using the service.

We asked staff how they safeguarded people from abuse. The registered manager said, "There are many types of abuse; financial, neglect of the basics such as food, if you noticed unexplained bruising on a person, or even just a change in their behaviour. We have body maps to record bruising, we would always collect the information and contact the local safeguarding authority." There were policies and procedures in place to provide guidance for staff on how to make a safeguarding referral and all staff were provided with training on safeguarding vulnerable adults. There was also a whistleblowing policy, enabling staff to raise any concerns without fear of reprisal.

We reviewed the service's systems and processes around medicines management. Staff were provided with training in medicines management, and competency checks were conducted before they were able to administer medicines independently. Medicines risk assessments reviewed people's understanding of their medicines, how they were stored and if there were any other risks such as an inability to swallow oral medicines. We reviewed medicines administration records (MARs) and found them to provide clear guidance for staff on what medicines people took and how often they took them. MARs were completed accurately. There were documents in place for medicines that were given 'as and when required' and these provided good detail for staff as to why people needed these medicines, when they would need them and what the maximum dose was in a 24-hour period.

Individual risks to people were assessed appropriately, with clear guidelines for staff on how to mitigate them. For example, in one person's risk assessment for a decline in their health, staff were instructed to continuously monitor and report changes in their behaviour to the registered manager. There were also general risk assessments, for example an environmental risk assessment included information about people's homes relevant to health and safety. For example, any fire precautions, electricity and gas outlets, any chemicals held and any specialised equipment in the property.

There was an ample stock of personal protective equipment (PPE) available at the office. Staff induction included infection prevention training and spot checks conducted by the registered manager ensured that

PPE was worn during the provision of personal care.

There were procedures in place to record and investigate accidents and incidents, however none had taken place since the service had registered.

Good

Is the service effective?

Our findings

A relative we spoke with said they felt that staff were well trained, saying, "They have the right training, they seem to know what they are doing."

New staff were supported with an induction that gave an overview of the service's vision and beliefs. New staff were required to complete 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 sector. It's made up of 15 minimum standards that should be covered if you are new to care work.

Staff completed training the provider considered mandatory. This included equality and diversity, safeguarding, dementia, basic life support and infection prevention. The service used a training matrix to identify when courses were due to be retaken, to ensure staff competency was maintained. Staff had received additional training in response to people's needs, for example where one service user lived with an autism spectrum related condition staff had completed autism and learning disability awareness training.

Staff received a consistent programme of supervision. This was initially every two to three weeks during the induction period and then quarterly. Supervision records we reviewed contained feedback from staff and the registered manager, with agreed outcomes and a reflection on what further support may be needed.

New staff also 'shadowed' experienced staff on shifts. The registered manager conducted regular spot checks which asked questions such as, 'is the staff member on time', 'are they wearing the correct uniform', 'have they asked the person's consent'. The spot check also included space for relatives and people to give their feedback on the performance of the staff member. Staff also received an annual appraisal.

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 MCA 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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). For services in the community, applications to deprive someone of their liberty are made through the court of protection.

We checked whether the service was working within the principles of the MCA and we found it was. People's capacity to consent to their care and support arrangements was assessed by the local authority and a profile sent to the service. Feedback from the local authority had resulted in the service designing its own capacity assessment which conformed to good practice. The registered manager understood how to record and implement relevant information, such as court of protection orders and best interest decisions.

People were supported to maintain their health and wellbeing by staff. People had logs of visits with healthcare professionals with any relevant updates for staff, for example where a G.P. came to visit there was

clear information about what changes to the person's care were needed.

Food and fluid charts were available, however nobody using the service required their nutritional intake monitored at the time of the inspection. People's nutritional requirements were recorded in detail in their care plans.

Good

Is the service caring?

Our findings

A relative we spoke with told us that staff were always kind and respectful. They said, "They are the best carers we've had actually, very prompt, very caring, always wanting to do more."

We asked staff how they maintained people's privacy and dignity They said, "It's about making sure you treat them with respect and give them space." The staff member described how they encouraged one person to wear a dressing gown around the house, to protect their dignity. A relative we spoke with said, "They always close doors and dress them very well."

The service had its own 'aims' as part of its values. These were linked to various aspects of people's care, one of which was 'independence and ability'. This included helping people choose what they wanted to wear or eat. In one person's routine it guided staff to 'always offer them a choice of where they want to go'. Documents used person centred questions such as, 'how would you like to be addressed?' to help build a profile of the person so their independence could be promoted and maintained. One relative said, "They care for [Name] properly, they know and understand them"

Care plans contained information about people's religious preferences, whether they wanted to be supported by a male or female member of staff, and how their needs could be practically met. The registered manager said, "At the assessment stage we discuss the person's religious and cultural preferences, any specific dietary needs to be aware of and if they have any preferences for male or female staff."

One person who staff had supported spoke English fluently however they also spoke a language other than English. Staff had recorded in their care plan words they had learned from relatives to make communication more comfortable and personalised for them such as water and food, even though they were able to communicate their needs in English. They also learned how to change their television to their favourite channels in their first language.

There was information provided to people on how to access an advocate. An advocate is someone who provides independent support to help vulnerable people understand their rights and express their wishes.

Good

Is the service responsive?

Our findings

People were assessed before using the service to ensure their needs could be met. This included the completion of a personal profile with information about their cultural and spiritual needs, social network and life history. The assessment also detailed their medical history, healthcare needs and health and social care professional network.

Care plans contained detailed, person centred guidance on how to meet people's needs and care for them effectively. For example, one person's morning routine instructed staff that the person was likely to be awake and pacing, for staff to greet them and help them bathe. There were further detailed instructions on how to minimise distress and maintain privacy and dignity. This was linked to the person's personalised 'outcomes' of hygiene, health and independence. Another care plan for nutrition and hydration further demonstrated the service had recorded personalised information about people's likes, dislikes, and how they wanted to be supported. The plan stated, 'I don't like sugary drinks. I require my food be cut up into finger food. I eat fast, please supervise me to avoid overfilling my mouth. Ensure food is not too hot to prevent scalds.'

Care plans were reviewed regularly, or in response to a change in circumstances such as a decline in mobility or health. One relative we spoke with said, "We have a review regularly to discuss what changes are needed."

The service helped people maintain active social lives and participate in activities that were meaningful to them. Care plans contained a list of their hobbies, likes and interests, as well as what they did not like. For example, in one person's care plan it instructed staff that the person did not like busy places.

Daily notes reflected the agreed routine in their care plans and preferred social activities. For example, one entry read, 'Showed [Name] two pictures of places to go, [Name] got excited and chose to go to...' A relative we spoke with said, "They always involve [Name], it's very difficult finding things to entertain them. We use Arch Healthcare Ltd if we go on holiday as well, they are very flexible."

The service was meeting the principles of the Accessible Information Standard (AIS). 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. The service user information pack, for example, was available in large print, braille and other mediums and there was information about communication needs in people's care plans. Information was also available in other languages if required.

There was a complaints policy in place and people received information on how to make a formal complaint. The policy informed people how they could expect their complaint to be managed and responded to. The service had received no complaints since it had registered.

The service did not deliver end of life care but the registered manager understood their role and

responsibility in working with partner organisations. They also demonstrated a good understanding of 'do not attempt cardiopulmonary resuscitation' documents. They informed us that training was available should they require it.

Good

Is the service well-led?

Our findings

There was a clear vision for the future development of the service which included recruiting staff to meet the needs of people across Yorkshire and becoming an approved provider with more local authorities. The provider sent everyone who used the service an information pack which included the aims of the service. These aims included a commitment to providing flexible care, promoting independence and ability to working with other health and social care organisations. The welcome pack also included a profile of the registered manager, their background, how care staff are monitored, how to make a complaint and details of how to contact CQC. This demonstrated a commitment to working in a transparent and accessible way.

We reviewed the service's quality assurance processes and found them to be robust. For example, audits of daily notes interrogated whether the notes were clear, free of abbreviation or offensive language and in black ink. There were audits of medicines administration records and care plans. For example, we saw an audit where the registered manager had identified that some notes were generic and offered advice for the staff member on how to improve the level of detail recorded. There were policies and schedules in place to audit complaints, accidents and incidents and safeguarding referrals, however there had not been any to review since the service registered.

The service engaged proactively with people that used it. This included a satisfaction survey, which asked people, among other things, if the standard of care was good, if the person's needs were met, and if people were supported to maintain their independence as much as they wanted. This was sent every three months. Surveys we reviewed gave unanimously positive feedback. Where one relative commented on the variety of a person's diet, we saw this had been acted upon by the registered manager. A relative we spoke to said, "The manager is approachable and always ask if there is anything they can do more."

The service demonstrated a willingness to engage in partnership working. For example, we saw that a visit conducted by the local authority had resulted in some recommendations and an action plan which the service had followed in order to make improvements to the service.

The registered manager understood the service's legal obligation to send statutory notifications to the CQC. We reviewed notifications sent to us and these were completed correctly and in a timely way.