Age Concern Newcastle Upon Tyne

Age UK Newcastle

Inspection report

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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**

Overall summary

This inspection took place on 21 and 22 October 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure the registered manager was available to assist the inspection.

We last inspected this service in July 2014. At that inspection we found the service was meeting all the legal requirements in place at the time.

Age UK Newcastle is a domiciliary care agency that provides personal care to adults and older people, some of whom may have a dementia-related condition. It does not provide nursing care. It provided personal care to 66 adults and older people at the time of this inspection.

The service had a registered manager who had been in post for one year. 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.

All staff had been trained to recognise and respond to any safeguarding issues. The service acted appropriately in reporting such issues to the local safeguarding adults

Summary of findings

unit. People told us they felt safe when their care workers were in their house. However, the service had failed to notify the Care Quality Commission about a number of safeguarding incidents.

Risks to people and to staff were assessed, and appropriate control measures were put in place to minimise harm to people. Accidents were recorded and analysed, to see if any lessons could be learned. Plans were in place to keep people safe in the event of an emergency such as severe weather or sudden staff shortages.

The registered manager was aware of the new legal Duty of Candour they owed to people, where something had gone wrong with their care.

There was sufficient staff hours available to meet people's needs safely and effectively. Staff recruitment was professional and robust, and ensured unsuitable applicants were not employed.

Staff were trained in the safe administration of people's medicines and had their competency to do so checked regularly.

Staff received a wide range of training to enable them to meet people's needs. Staff were given support by means of supervision and annual appraisal. People told us they felt staff had the skills they needed.

People were asked to give their consent to their care. However, where people were not able to give informed consent, their rights under the Mental Capacity Act 2005 were not being fully protected.

People were supported with their nutritional needs and with their general health needs.

People told us their care workers were very kind and caring and treated them with respect at all times. They said their privacy and dignity were protected and they were encouraged to be as independent as they were able.

People were provided with information about their rights and about the services available to them, such as benefits checks and lunch clubs.

People and their relatives were involved in deciding what their care needs were and how they wished them to be met. Care plans were clear and detailed, and reflected people's preferences. Regular meetings were held to review each person's care.

The service recognised the danger of social isolation affecting people's well-being. People were encouraged by staff to maintain interests, contact with their families and use local community facilities such as day centres and lunch clubs.

The service had recently gone through a major review of its aims and objectives. It had concluded it would be better able to meet people's needs by withdrawing from its contract with the local authority and providing services mainly to people funding their own care. The provider told us this had given them the scope to plan services which were not constrained by rigid time slots and which would be more centred on the needs of the individual. As a result, the service now provided services to a smaller number of people and was able to demonstrate a significantly better person-focussed approach.

The management team was open, responsive, approachable and keen to improve the quality of the service in all areas. Systems were in place to monitor the performance of the service. People told us they felt they were listened to and were able to influence how their service should be given.

The service had forged links with other Age UK branches to explore potential for economies of scale, share best practice and organisational learning.

We found breaches of the Health and Social Care Act (Regulated Activities) Regulations 2010 in relation to obtaining people's consent to their care and the notification of incidents. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff were trained to recognise and respond to any suspicion of abuse.

Risks to people receiving a service were assessed and steps were taken to keep people safe from harm.

People received appropriate support to take their medicines safely.

Good

Is the service effective?
The service was not fully effective. People's rights under the Mental Capacity Act 2005 were not always respected.

Staff had been given the training they needed to meet people's needs effectively.

Staff were given support to carry out their duties by means of regular supervision and appraisal.

People's health needs were assessed and met.

Requires improvement

Is the service caring?
The service was caring.

People told us their care workers were kind and caring, and treated them with respect.

People's privacy and dignity were protected.

People were given the information they needed about their service and were encouraged to be as independent as possible.

Good

Is the service responsive?
The service was responsive.

People were involved in assessing their needs and in deciding how they wanted those needs to be met.

People's care was person-centred.

Complaints were taken seriously and responded to appropriately.

Staff took steps to prevent people becoming socially isolated.

Good

Is the service well-led?
The service was not always well led. There had been a failure to notify us of safeguarding incidents.

Requires improvement

Summary of findings

The management team had improved the focus on individualised care, and efficiency and effectiveness of the service.

Systems were in place to capture the views of people, their relatives and staff, and those views were taken seriously and acted upon.

The quality of the service was kept under constant review and steps were taken to address any deficits.

Age UK Newcastle

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.

This inspection took place on 21 and 22 October 2015. The inspection was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure the registered manager was available to assist the inspection.

The inspection team was made up of one adult social care inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

We contacted other agencies such as local authorities and Healthwatch to gain their experiences of the service. We received no information of concern from these agencies.

As part of the inspection we sent questionnaires to 50 people who used the service and 50 relatives/visitors. We spoke with the registered manager, the provider's nominated individual, one home support worker, the office manager, and eight care and office staff. We 'pathway tracked' the care of three people, by looking at their care records, visiting them in their homes, talking with them and staff about their care. We spoke with four relatives. We reviewed a sample of six people's care records; four staff personnel files; and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe with their workers. One person told us, "I'm safe. I trust my carers." Relatives agreed, and told us they had no concerns about the safety of the service. A typical comment was, "We have no complaints or concerns at all." In a Care Quality Commission survey all the 21 people and three relatives who responded told us they felt safe from abuse or harm from their workers.

We looked at how the service protected people who used its service from harm or abuse. A safeguarding policy and procedure was in place, which had recently been revised in line with recent changes in legislation. We saw all care workers had been trained in the safeguarding of vulnerable people. We noted people had a 'Cause for concern' form included in the information they had been given about the service, and that this was available for the person, their relatives or representatives to use to flag up any issues they might have.

We examined the safeguarding records held. These demonstrated the service acted promptly in recognising and reporting safeguarding issues to the local authority adult safeguarding team. Where requested to carry out internal investigations on behalf of the safeguarding team, these were seen to be thorough. Actions were taken to address any issues, including disciplinary processes, where necessary.

The registered manager was aware of the new 'Duty of Candour' legislation which required them to accept responsibility for any harm caused by the service to any individual and take appropriate steps to apologise and rectify the situation. They told us they were booked on training with regard to this duty.

The service had a 'whistle blowing' policy which required staff to immediately report any bad practice they observed. We saw evidence that issues raised by whistle blowers were routinely passed onto the service's chief executive.

The service assisted only three people with their personal financial transactions, such as shopping. Financial activity sheets, with associated receipts for purchases, were kept to record handling of the person's cash. We pointed out that one person's finance sheets had not been recently audited and two people did not routinely countersign each transaction. The registered manager told us this would be addressed immediately.

We noted staff were trained in anti-discriminatory practices. None of the people and relatives we spoke with had any concerns about any form of discrimination or restriction of their human rights.

General risks to people using the service and to staff were assessed. Examples seen included, fire safety, risk from chemical cleaning products and handling people's personal cash. Appropriate control measures were recorded. The risks to individuals, such as from falls, medicine administration and moving and transferring, were also assessed, with a record of the steps taken to minimise the assessed risk.

The service had a 'business continuity' plan in place. This gave guidance on how to maintain people's safety in the event of, for example, severe weather, systems failure and staff shortages. An emergency pack containing key documents, records and equipment was held off-site.

The service had a procedure for reporting accidents and incidents, and a quarterly report was made to the Trustees regarding the numbers and seriousness of the accidents and the remedial actions taken to minimise the likelihood of the event occurring again. We noted only one accident had been logged in the previous quarter. We saw this had been analysed and steps taken to retrain staff.

The registered manager told us staffing levels and staff hours were negotiated with the person using the service, as the large majority of people currently funded their own care. They told us this gave the person more flexibility in their service. Where a referral was received from a local authority, the required hours were agreed with the referring social worker, on behalf of the person.

The service had robust systems in place to make sure only suitable applicants were employed to work with vulnerable people. These included checks of identity, any criminal convictions and work permits, taking up references from recent employers and asking for a full employment history. Interviews were recorded in good detail. Staff we spoke with confirmed their recruitment process had been thorough.

The service had an appropriate policy in place for supporting people with their medicines. All staff who administered medicines had been trained and their competence was checked every three months. The registered manager told us staff were taken off calls where administration of medicines was required if they failed to

Good

Is the service safe?

demonstrate such competence, and they were subsequently retrained. Each person's medicines administration record (MAR) was collected and returned to the office for auditing every four weeks. We looked at a sample of 25 MARs and saw that the auditing process was effective in picking up errors or anomalies. Issues such as unexplained gaps were identified and taken up and investigated. The registered manager told us staff reported any issues they found between audits to the office. We saw each person's care record included a medicines risk assessment and care plan, and a medicines incident form. A relative told us, "The staff seem very aware of medicines. They don't just hand them out."

Requires improvement

Is the service effective?

Our findings

We sent surveys to people who used the service to ask their views. 70% of the 20 people who responded told us they received care from familiar, consistent workers.

We spoke with relatives of people who used the service. They told us the service was consistent, reliable, flexible and met their relative's needs. They said the care workers did little 'extras' when requested, such as collecting a person's medicine prescription. One relative told us, "The staff seem to be skilled and well-trained."

People told us their care workers had the skills and knowledge to give them the care and support they needed. A typical comment was, "As a relatively recent user of the service I have no reason to doubt their skills and knowledge are appropriate." People told us their workers generally arrived on time, completed their tasks and always stayed for the agreed length of time. A large majority of people (85%) using the service said they would recommend it to other people.

New staff were required to complete a 12 week induction programme which covered areas such as their role, communication, health and safety, equality and inclusion, and their duty of care. As part of their induction new staff shadowed more experienced workers until they were judged to be competent in carrying out their roles effectively. The registered manager told us they were working with a local training agency to ensure this induction programme was compliant with the requirements of the new Care Certificate.

The service had a programme of regular staff training in place, which covered all the areas of training necessary to maintain the health and safety of people using the service and of the staff themselves. The staff training matrix demonstrated all staff (other than those on long term sick or maternity leave) were up to date with their required training. We were shown the computerised system that flagged up when each staff member was due for further training. We saw that 22 of the 55 care workers employed had either achieved, or were working towards, 'Qualifications and Training Framework' (QCF) qualifications in care.

The service provided formal supervision to its workers on a three monthly basis. This was provided in both one-to-one and group sessions and by on-site observation of their work. Areas covered included health and safety, safeguarding, training needs, working patterns and policy areas. Minutes of supervision meetings showed the process also allowed workers to raise issues of their choice, and indicated a high degree of work satisfaction on the part of the workers. Each staff member was given an annual appraisal of their work. We noted this did not currently include setting clear targets for the coming year.

People were asked to sign a 'consent to care' form to show they agreed to the provision of their care. People were reminded in the document they had the right to withdraw their consent at any time.

A policy for the implementation of the Mental Capacity Act (MCA) 2005 was in place, and all staff had received training in the implications of this legislation. Appropriate documentation was available for the assessment of a person's mental capacity to give informed consent to their care. However, we saw this was not used as part of the person's assessment of need before a service was commenced. This meant some people may have been asked to give their consent to receiving personal care where they lacked the capacity to make such a decision. For example, it was evident, in one person's care record that they were clearly unable to understand or give their consent to elements of their care plan. It was stated, "(Name) does not know and understand what medicines they should be taking." This person had been allowed to sign a form consenting to workers administering their medicines, dealing with some financial affairs and providing intimate personal care. We saw no evidence of any 'best interest' decision making process being carried out by professionals and family members/representatives on the person's behalf. This would have protected their rights under the MCA.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Act 2014.

People's dietary needs were assessed. Special diets, allergies and the person's food and drink preferences were included in their care plan. Where a person needed specialist assistance with their diet, workers were given training by a relevant professional such as a district nurse and their competence checked before they gave this support.

People's general health needs were assessed and any current inputs or treatment from health professionals was

Requires improvement

Is the service effective?

recorded. The registered manager told us workers were instructed to ring the office with any concerns they might have about a person's health. This was confirmed in the staff handbook. Senior staff would then make any necessary referral to other health services. Similarly, workers reported if a person was in need of any specialist equipment such mobility aids, smoke detectors or fire alarms, and approaches were made to the relevant loan services agency.

Good

Is the service caring?

Our findings

We sent surveys to people who used the service and their relatives to ask their views. All who responded said their care workers were caring and kind. All the three relatives who responded, and 19 of the 20 people, told us they were happy with the care and support they received from the service. One person said, "I get on well with my carers and have a good relationship with them."

We also spoke with people's relatives by phone. They told us they felt the service was very caring. Comments from relatives included, "Carers are very amenable and helpful"; "They are definitely caring and compassionate"; "Staff are very attentive. My relative has formed a good bond with their workers"; and, "They are very nice, caring and polite."

We noted in the service's compliments book, comments such as, "Thank you for first class care"; and, "You made Mum feel important, that she was worth talking to, that she was human and not just a body."

The registered manager told us the staff recruitment process was specifically aimed at 'filtering in' caring and compassionate candidates and that those without such characteristics were not employed.

The service had a policy to promote equality and diversity and trained all staff in this area. People's religious observance, ethnic origin and cultural requirements were recorded and included in their care plan, where relevant. People's physical, emotional, psychological and social needs were also considered when drawing up their plan of care.

People were given a 'customer guide' which set out the service's aims and objectives, available services, charges, complaints and quality assurance policies. Information on how to contact other agencies such as the NHS and Care Quality Commission (CQC) was included in this guide. Information was available in large print, on tape, in different languages and in Braille.

The registered manager told us the staff team were committed to enhancing people's well-being in any ways they could. We were given examples of episodes of good practice by care workers. These included arranging for a person's boiler to be repaired the day it broke down, accompanying a person on trips abroad, volunteering to take a person to an airport, without charge and volunteering to work without pay on Christmas Day, so people who would otherwise be alone could attend an Age UK Newcastle Christmas party.

In their initial assessment of needs, people were asked if they wished to make decisions about their care alone, or if they preferred to talk to someone else first. People confirmed to us that the service listened to any family member, friend or other representative they nominated to speak on their behalf. The registered manager told us a letter had been sent to people using the service informing them of the availability of the Age UK Newcastle information and advice team. We noted, however, there was no formal policy on advocacy and it was not referred to in the 'customer guide'. The registered manager told us this would be addressed as a priority.

Staff were given training on the importance of maintaining people's confidential information as part of their induction and signed a 'data security compliance' statement. We saw an information security policy was in place. No one we spoke with raised any concerns about confidentiality.

All the people we asked told us they were always treated with respect and dignity. This was mirrored by a recent Age UK Newcastle survey of people's views, where 92% said they were treated with respect. We saw people's dignity was a focus in their care planning, with examples seen such as, "Treat me with dignity and respect my opinions and personal values" and "Be aware of my cultural needs and requirements." One person using the service told us, "They always ask my permission before doing anything and they treat me with respect."

The service had a policy for 'personalisation' with the stated aim of enabling people to live the lives they chose. Included in the policy was the need for workers to weigh the risks of a person's actions against the benefits they would gain from it. Staff were reminded of the importance of not using risk as an excuse to restrict people's lives. All the people whose views we sought told us the support they received helped them to be as independent as they could be. We saw references in people's care plans such, "I can manage most tasks myself but would like help with washing my legs and back" and "Make sure (name) has their hearing aids in."

The danger of people becoming socially isolated was recognised and people's hobbies, interests and

Good

Is the service caring?

relationships were recorded and supported. Examples seen included assisting people in visiting local community facilities and in trips out. One person was supported by their workers on a holiday abroad. People were asked, as part of their initial assessment, if they needed help to maintain contact with family members. Workers reported any concerns about isolation or withdrawal by the person. Information was provided about the wider services and opportunities available to people, including lunch clubs and day centres.

One home support manager had undertaken a 'train the trainer' course in end of life care, with the aim of rolling out this training to all workers. We were told that 14 workers had already been trained in palliative care. We saw, in the compliments log, a letter from a relative, who said, "Your staff made (my relative's) last few months as comfortable as possible. There were laughter and tears and your ladies helped us through it all."

Good

Is the service responsive?

Our findings

People told us their service was responsive to their needs. One person said, "My carers are always happy to help and complete all tasks I ask of them." A second person commented, "In most cases I am content with this agency. They are helpful if changes of carers have to be made." Another person told us, "The staff give my care as I want it."

Relatives told us the service was responsive to the needs of their relative. One relative told us, "They do things the way we ask, and are very flexible. The office lets us know of any changes from their end, such as if the carer has been delayed." Another relative said, "The staff and the office are responsive, they answer promptly."

Staff were given training in person-centred care and support as part of their induction. The assessment process included asking people to complete a personal history, to introduce them to their workers and helped staff understand them as individuals, and not just as recipients of care.

An assessment of the person's physical and mental health needs, medicines, social and family background, and independence skills had been completed. People and their relatives told us they were involved in this assessment process and in decision-making about their care and support needs.

Care plans were drawn up to meet people's assessed need. As well as describing needs, care plans were written in the first person and included the person's preferences as to how they wanted their care to be given. Care tasks were broken down into clear steps to assist the worker in providing care effectively. We saw examples such as, "I would like my care assistant to assist me to undress and I will get into the shower one leg at a time using the grab rail to assist me."

People's care was reviewed at least annually and a computer system flagged up when each person's review was due. Reviews involved the person and their family, covered areas such as the person's relationship with their workers, any changes required to the care plan and any improvements that could be made to the service. The comments of the person, their relatives and the person's care workers were recorded and the review form signed by all.

A log was kept of all concerns and complaints. Six issues had been recorded in 2015. Entries were clear, detailed and professional. They included investigation findings, staff interviews and other actions taken. Although it was evident that action had been taken regarding all complaints, the outcomes of two were unclear. The registered manager said this would be addressed immediately.

People told us they knew how to make a complaint. They said their workers responded well to any complaints or concerns they raised, as did office staff. Most people said they had not made complaints. One person said, "I have never had cause to complain or raise concerns." A relative told us, "There's been a few little issues, but they have been sorted out quickly."

We saw evidence that the service worked with another company to facilitate the transfer of the care of a number of people. Existing care documents had been passed to the new company, information had been shared and a staggered handover of services arranged to minimise disruption to those people transferring. A number of workers had also transferred under the Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) which had ensured continuity of care.

Requires improvement

Is the service well-led?

Our findings

The service had a registered manager in post, who had been in post for one year.

People told us they were happy with the way their care was managed. They said they knew who to contact in the agency if they needed to, received information that was clear and easy to understand and were asked by the agency what they thought about their service.

A typical comment was, "I'm happy with my care" When asked how their service could be improved, this person told us they did not think it could be.

Relatives said the service was well-organised and kept them up to date with any changes or developments. Relatives confirmed they also knew who to contact and were asked for their views about the service. One relative commented, "I've seen significant improvements in recent months." Another relative commented, "They keep me 'in the loop'." A third relative told us they received surveys and also got told the results and what the service was going to do about them.

The service's chief executive told us there had been significant changes to the service provision over the previous twelve months. An economic decision had been made to withdraw from its contract with the local authority and concentrate on working with people who funded their own care. They said this had enabled the service to give longer and more flexible care packages that better reflected people's individual needs and wishes. It had also allowed staff the time to review and improve systems, policies and record keeping.

We found the service to be better focussed and able to provide more consistent, person centred care than at the previous inspection. We found an open and accountable culture in the service. Staff at all levels were responsive and reflective, and welcomed suggestions for improving the service. Staff were asked for their comments in surveys, in training evaluation forms and at the end of their induction. Staff told us they were expected to give their views on the service. One staff member told us, "We are encouraged to raise issues, and I've never had a negative response when I have. If they (management team) don't know the answers, they will find out and tell me."

The views of people using the service and their relatives were also regularly surveyed. We found these surveys were comprehensive, well-collated and analysed, with both positive and negative feedback captured. Issues such as the quality and consistency of people's care, communication issues and individuals' specific concerns were appropriately addressed. A plan of action was in place to address the issues raised. This included examples such as the introduction of teams of workers (including reserve workers to cover sickness and staff holidays) known to each person, to improve consistency of care.

The service had a policy on the notification of significant events. We noted the 'Age UK CQC Self-Assessment' document used by the service prompted the service to be aware of its responsibility to meet CQC registration requirements, including the submission of notifications. Our records showed, however, the service had not notified the CQC of 16 reportable incidents that affected the health, safety and welfare of people using the service over a 16 month period prior to this inspection. We discussed this with the registered manager who told us they had not been aware of their responsibilities regarding such notifications. The registered manager has subsequently formally notified CQC of these outstanding issues and other notifiable incidents since this inspection.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

We will take further action regarding this and will report on the outcome when this is concluded.

The service had a range of systems in use for monitoring the quality of the service provided. The service had an annual audit by an independent company to ensure it met the standards of the national Age UK quality standards. For internal auditing purposes, the registered manager used a self-assessment tool, which was mapped against the 'key lines of enquiry' used by the CQC to judge compliance with legal requirements. Audits were carried out every two weeks by the service's registered manager and quality manager. These covered areas such as care records, medicines records and staff files (including supervision and training). A post-induction staff survey was completed and there were regular quality monitoring phone calls to people who received a service. Issues identified as needing improvement were incorporated into an ongoing improvement plan.

Requires improvement

Is the service well-led?

The registered manager told us the service was working towards the ISO 9001 certified quality management system and the Contractors Health and Safety Assessment scheme. They told us there had been benefits accrued from the process of self-assessment required to achieve these quality marks, including reviewing all policies, restructuring the management of the service and retraining staff.

The service used an integrated software system to improve the quality of the service provided. This system recorded care workers' skills, training and competencies, matching them against the assessed needs of people using the service. This allowed people to have their preferences for, as an example, a male or a female worker, and to specify workers they preferred not to use or always wished to use. It also meant that if a person had specialist needs they would only be allocated a worker who had been trained in meeting those needs. This information was used to generate workers' time sheets that reflected people's wishes and needs.

The system was also used to co-ordinate a range of variables including the person's care plan (for example, where there was a specific time for taking medicines), their preferred worker(s), staff travel times and distances, to ensure planning met people's needs.

We found the quality of record keeping in the service to be of a good standard. Records were clear, up to date, accessible and securely stored.

The service was engaged in improving its partnership working with other agencies and organisations. One example of this was working with a local NHS hospital trust's Older People's wards to monitor and feedback on people's experiences of their hospital stays and discharges. Another example was that the registered manager was a member of the local authority safeguarding adults 'Improving Practice' review group. The registered manager and other senior managers were members of a range of representative and development bodies, including the local authority Safeguarding Improvement Group; the 'Services for older people consortium committee'; and the 'Independence at Home' support network. The service is a member of the United Kingdom Home Care Association.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider had not acted in accordance with the Mental Capacity Act 2005, when a person was unable to give consent because they lacked the capacity to do so. Regulation 11 (3).