Absolute Care At Home Ltd

Absolute Care at Home Limited Head Office

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

This was a planned inspection and the first day was unannounced. We visited the office location on 22 May 2018 to see the registered manager, care manager, a senior care worker and office staff, to review care records and policies and procedures. On the 23 and 24 May we visited people who used the service in their homes (with their permission) and made phone calls to people who used the service, relatives and members of the staff team.

This service 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 170 older adults in the Trafford area.

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 place at the service who was also one of the company directors. They had been registered since 2006. 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.

At our last inspection in April 2017 we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2104. These were in regard to not meeting the requirements of the Mental Capacity Act (2005) where people lacked the capacity to agree to their care and support, the documenting of any medicines administered and the auditing of the medicine administration records (MARs).

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, effective and well led to at least good. At this inspection we found improvements had been made and the Regulations were now being met.

Medicines were administered as prescribed and the MARs were completed by staff. Care plans clearly identified the support people required when taking their medication. MARs were audited each month and a system was now in place to follow up any missed signatures or errors found with the staff member concerned.

Where people may lack the capacity to make decisions about their care and support a capacity assessment was completed. If it was assessed that the person lacked capacity a best interest decision was made, involving the relevant people, for example family members. People's capacity was re-assessed at each review of their care; however, this was not formally documented. We have made a recommendation to follow best practice guidance for recording all areas reviewed.

People told us the care staff were kind and caring. People felt safe when the Absolute Care At Home staff

visited them and said the staff maintained their privacy and dignity when providing support. The staff knew people and their needs well and were able to explain the safeguarding procedures in place if they had any concerns.

Travel time was not built into staff members rotas. Therefore, it was accepted practice that visits were shorter than commissioned to enable staff to travel to the next person's house. People told us this was not an issue and staff would always ask if there was anything else the person wanted them to do before they left. Staff told us that their calls were all close together so there was limited travel time involved between calls.

People told us there were very few missed calls. The cause of any missed calls was investigated and action taken where required. People told us that their visits could be late and they were not always informed about this. Regular staff supported people, although this was more variable for the evening calls.

There was a safe recruitment process in place. Staff received the induction and training to carry out their role. Staff had regular supervision meetings and an annual appraisal. Regular unannounced spot checks were completed by senior members of staff to check staff members competencies.

Staff were kept up to date with any changes in people's support needs through the daily notes and a weekly bulletin sent out to all staff by the provider.

People and their relatives were involved in developing and reviewing their care and support plans. They said they received the support they had agreed to.

A system was in place for recording and following up any incidents or accidents. A complaints process was in place and records showed verbal and written concerns were responded to in line with the service's policy.

The quality assurance system had been improved since our last inspection meaning the registered manager had oversight of the service and acted on any issues found. Surveys were used to obtain feedback about the service. The responses were positive and any concerns raised on the survey returns had been appropriately addressed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were administered as prescribed and recorded on Medicine Administration Records (MARs).

Risks were identified and reduced where possible. These were regularly reviewed to ensure they were current.

People felt safe supported by the service. There were few missed visits, although people told us calls could be late. Any missed calls were logged and followed up with the staff member concerned.

Is the service effective?

Good

The service was effective.

People's capacity to consent to their care and support was assessed. Best interest decisions were made if people were assessed as lacking capacity.

Staff received the induction, training and support to carry out their roles.

Is the service caring?

Good

The service was caring.

Staff knew people's needs and preferences.

People said the staff were kind and caring and maintained their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Care plans clearly identified the support people needed and were regularly reviewed.

Staff were kept up to date with any changes in people's needs

through a weekly bulletin and daily records of the support provided.

People and relatives said they were able to raise any concerns with the managers of the service. A formal complaints system was in place.

Is the service well-led?

Good

The service was well-led.

The quality assurance systems had been improved. Effective medicines audits were now in place. Any areas for improvement identified in the audits were acted upon.

An annual survey was used to obtain feedback about the service. This was seen to be positive, with any concerns raised followed up by the service.

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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.

This was a planned inspection and the first day was unannounced. Our inspection site visit activity started on 22 May 2018 and ended on 24 May 2018. It included visits to seven people's homes (with their permission) and phone calls by arrangement to nine people who used the service, four relatives and nine care staff. We visited the office location on 22 May 2018 to see the registered manager, care manager, a senior care worker and office staff, to review care records and policies and procedures.

Two inspectors visited the office location and made the home visits. An expert by experience and one inspector made phone calls to people who used the service and two inspectors telephoned the members of care staff. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of services for older people.

The provider had completed a Provider Information Return (PIR) prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information that we held about the service including notifications made to the Care Quality Commission. A notification is information about important events which the service is required to send us by law.

We contacted the local authority commissioning and safeguarding teams. No concerns were raised with us about Absolute Care at Home. We also contacted Trafford Healthwatch who said they did not have any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We looked at six care files at the service's offices and seven care files in people's homes. We viewed records relating to the management of the service such as the staffing rota, missed call logs, incident and accident records, five staff recruitment files and training records, meeting minutes and auditing systems.

Good

Is the service safe?

Our findings

All the people we spoke with said they felt safe when being supported by Absolute Care at Home staff. One person said, "Absolutely, and they (the staff) wouldn't leave unless I was safe" and another told us, "Yes, they are very good. I have never felt unsafe with them."

At the last inspection we found a breach in regulation 12 as medicines administration charts (MARs) had not always been completed correctly by care staff and we noted a number of gaps on the MARs. At this inspection we found improvements had been made and this regulation was now being met.

Some of the people using the service were supported with their medicines. Care plans clearly stated whether the staff supported people with their medicines or if they were self-medicating or supported by their family. We viewed MARs in people's homes and at the office. We found these were completed as required. Where gaps were seen the reason was noted on the MARs, for example family visited and so they supported the person with their medication. The MARs were checked each month by a senior care staff member. If any gaps or omissions were found the seniors followed this up with the staff member concerned using a four-tier system which included talking to the staff member, re-training and formal disciplinary action if required. One staff member told us, "They're very strict. I forgot to sign a MAR sheet once and I got pulled (spoken with by a senior)."

We saw that the care plans gave clear instructions on where the cream should be applied and named the type of cream to be applied. All of the care workers had training in the administration of medication and we confirmed this by looking at the staff matrix. Annual observations were completed to check the staff member's competency in medicines administration.

People we spoke with said that staff always visited or that missed calls were rare. The service made around 2500 calls each week. The service recorded and investigated all missed calls. We saw that in the past three months there had been nine missed calls, all due to staff error when reading their rotas.

We received mixed feedback about whether the staff called at the agreed times. People accepted that sometimes staff were delayed due to traffic issues or because another person needed additional support that day. However, they said that they were not usually contacted to let them know if the staff were running very late. People told us, "They're very good at coming around the correct time, but if it's up to an hour late, I'll ring the office and they find out where they are", "The staff always turn up. If they are running late they tend to give me a call" and "They arrive on time, but some occasions they have been delayed due to their previous client. But this isn't an issue for me."

People told us that the morning calls tended to be the same staff and on time. However, the evening calls could be a mix of staff members and the times were more variable. A relative said, "Morning visits are usually good, but the evening visits can be haphazard." One person also told us, "[Staff member's name] is my main carer in a morning, but it can be various different ones in the evening." People told us that new staff always introduced themselves when they arrived and had an identity badge and uniform so they knew who they

were.

People were encouraged to contact the office or out of hours telephone number if the carer was late. The on-call manager would then contact the carer and if required, send an alternative staff member to cover the call.

It was still the services' practice not to provide travelling time on staff rotas. The registered manager said the local authority who commissioned the majority of care packages allowed care workers to leave care visits early by the equivalent of 10% of the total visit time. This time was used for travelling to the next person. We were told the calls were arranged so they were close together and staff were able to leave a call a few minutes early to travel to their next call. Staff confirmed this saying, "I do about 25 minutes for half hour call and then leave to get to the next one." People we spoke with said that staff always completed the agreed tasks and asked if there was anything else the person wanted them to do before they left. People said the staff would do additional things if they were asked to. The daily logs recorded the start and finish time of each call. The daily logs we saw confirmed staff stayed for the majority of the scheduled call, but left a few minutes early to travel to their next call.

At our last inspection we were told the service was looking to introduce an electronic rota and management system. This would enable the care manager to monitor that the planned calls were being made and would highlight any late calls. The care manager would then be able to contact the staff member and inform people that their calls were going to be late. This system was still in development at this inspection, although we were told it was due to be delivered to the service by the end of May 2018.

We spoke with the care co-ordinator who compiled the staff rotas for the service. They showed us how each run was organised and where any gaps in the run were. Therefore, if a new person wanted a call they would be offered one of the gaps; however, this did not always match with their preferred time for a visit. Any time critical visits, for example for specific medication, were prioritised on the rota. We noted that staff had regular runs of calls wherever possible.

The service had an out of hours service which ran until 11pm each night which meant care staff could contact a senior member of staff if they had any concerns when the office had closed. Any calls made to the out of hours service were logged and if any action was required either at the time of the call or the following day this was also recorded. There were two staff members available out of hours, one on 'stand by' in case the other staff member was required to attend a call to support staff. This ensured the service had systems in place to deal with issues and emergencies when the office was closed.

Robust recruitment procedures continued to be in place, with all pre-employment checks completed before a new staff member started to work for the service.

Staff were able to explain how they kept people safe whilst supporting them and the procedures used if they were concerned a person may be at risk of abuse. We noted that staff had raised concerns with the senior carers or managers, for example if people needed additional support. We also saw that a safeguarding referral had been made to the local authority where the service had concerns about their welfare. This meant the staff reported any concerns or changes in people's needs and these were acted upon by the managers at the service.

We saw that each person's care file contained risk assessments relating to the environment, medication and moving and handling. These were reviewed to ensure they met any changes in people's needs. Where people required the use of equipment to help them to move the care plan documented the specific type of

equipment needed to support the person.

The service kept a record of any accidents or incidents that occurred. These were recorded by the on-call manager where they occurred out of office hours. Accidents and incidents were reviewed by the registered manager and care manager with any action required to reduce a re-occurrence noted and implemented.

The service had a business continuity plan in place for any emergency situations, for example bad weather affecting staff travel to calls. Staff had access to personal protective equipment (PPE) such as gloves and people told us that the carers used them when they visited. One said, "Staff wear gloves and put them on as they come into the house every day."

Good

Is the service effective?

Our findings

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.

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 MCA states we should assume all people have the ability to make their own decisions; only when it is thought that a person may lack capacity are assessments required to establish if this is the case.

At our last inspection in April 2017 we found the service was not meeting the principles of the MCA as capacity assessments or best interest decisions had not been completed, which was a breach of regulation 11.

At this inspection we found improvements had been made and this regulation was now being met.
A capacity screening tool was used which stated the decisions that needed to be made, for example consent to their support, medication administration and personal care. Where people had capacity to make decisions no further assessment was made. People signed their own care plans to state they agreed with the identified support tasks. Where people lacked capacity a best interest decision, involving family members where appropriate, had been taken and documented. We saw this screening tool was not in all the care plans we viewed during our home visits. We discussed this with the registered manager who said 90% of people had the new capacity assessments in place and the remaining 10% would be completed by the end of May 2018.

We were told the capacity assessments were reviewed as part of each person's annual review; however, this was not recorded on the review document. We recommend that the review document is looked at in line with best practice guidance to record all areas and documents reviewed.

All the staff we spoke with said they had attended an induction when they joined the service and continued to complete annual refresher training. District nurses provided training where required for people's specific needs, for example catheter care.

The induction included taught courses in moving and handling, medicines administration and learning about the company's policies. E-learning courses were completed including dementia awareness, safeguarding vulnerable adults, equality and diversity, health and safety and infection control. Staff also shadowed experienced staff to get to know the people they would be supporting and their care needs.

Newly recruited staff were enrolled on the care certificate. The care certificate is a set of knowledge and skills care workers should adhere to. Staff were also encouraged to enrol on a nationally recognised

qualification in health and social care.

Staff had three supervisions per year and an annual appraisal. Unannounced spot checks were also carried out regularly, where a senior carer would observe a staff member during a call. Appraisal forms had recently been changed to make them more structured and examined overall performance, time management as well as any training needs or wishes the carer may have. Staff told us they felt well supported by the seniors, care manager and registered manager. One staff member said, "Absolutely feel supported, they are great, can always go to them at any time."

This meant staff had the induction, training and support to carry out their roles.

An initial assessment of people's support needs was undertaken for all new referrals. From this assessment an initial care plan was written. Staff told us they read the care plan and spoke with the person themselves when they first went to support them.

People's care plans detailed if people were supported with their nutrition. People we spoke with told us staff always asked them what they wanted to eat, offering them a choice each time. They also said that food and drinks were left for them to have between the staff visits. One person said, "[Staff name] does my lunch and leaves it in the fridge for me" and another told us, "I like cold tea so they leave me a few cups on the table for me." This meant people's nutritional needs were being met.

Staff told us they did not support people with their medical appointments unless it had been agreed by the funding authority. Most people did this for themselves or their families made any appointments needed. Staff did say that if they arrived and a person was unwell or had had an accident, such as a fall, they would report this to the office who would inform the person's family. If required the staff would contact the person's GP or 999 and stay with the person until the ambulance or their family arrived.

We did see that where required the service involved other professionals as required. For example, we saw that the service requested a moving and handling assessment for a person whose mobility had deteriorated. We noted that an occupational therapist had visited and provided a rota stand.

This meant the service supported people to meet their health needs.

Good

Is the service caring?

Our findings

We asked people and their relatives if they thought the care workers supporting them were kind and caring and the responses were all positive. People told us, "Oh yes they do, very caring staff come here", "Very caring staff, I feel they make sure I keep my dignity as much as I can", "They are nice and kind people – I have no problem with them." One person told us the carers were "Just like friends" and another said, "They are excellent for me and have made a huge difference to my life."

Care plans identified what tasks people were able to complete for themselves and what staff were to support people with. People we spoke with confirmed that staff promoted their independence. One relative told us, "They (the staff) let him do as much as he can himself" and one person said, "Staff let me do the things I can myself; I don't like them taking over."

Staff were also able to explain how they supported people to maintain their independence. We were told, "With personal care I give them choices. Let them wash where they can, try and keep them as independent as possible, for example by giving them the hairbrush" and another member of staff said, "Some people are very independent – I just supervise and let them do everything."

Everyone we spoke with said the staff treated them with dignity and respect. Staff had developed positive relationships with the people they supported and knew them and their likes and dislikes. One person told us, "They know me well and my routines; they know how I like to have things done." People told us staff offered them choices, for example what they wanted to eat or wear. Everyone also said that the staff asked at every visit if there was anything else the person wanted them to do before they left. One person said the staff assisted them to read their mail when asked to do so.

People and their relatives said they had been involved in developing their care plans and agreeing the support they needed. The care plans contained brief details about the person's personal history which meant the staff members knew a little about their background to talk about during their visits.

People's electronic and paper based information held at the office was securely stored, maintaining people's confidentiality.

Good

Is the service responsive?

Our findings

Each person supported by the service had a care plan in place. This included information contact details for other family members and medical professionals involved in the person's care. Each person had a copy of their care plan in their home, which the staff could refer to on their visits.

The care plan included an assessment of people's needs, for example how they communicated, vision, hearing, personal care, mobility and skin care. Care plans were individualised and person centred. They gave clear information on the support people needed and the tasks staff were to complete at each visit. Information was also provided on people's preferences for example the drinks and food they liked. People could specify if they wanted only male or female staff to support them. The registered manager told us they discussed this with people and endeavoured to meet their wishes wherever possible, however this was also dependent on whether there was a gap on a run that met this preference.

We looked at the daily records in the care files in people's homes. These forms had been reviewed since our last inspection. They included a tick sheet of the tasks completed at the visit and a written description of the support, food and fluids provided. The daily records corresponded with the support specified in the care plan. This meant the care staff documented the support they were providing and enabled the next staff member to visit to see what support had been provided.

The care plans were reviewed six weeks after the service started and then every six months or when people's needs changed. An annual review was held at the person's home, with their family if appropriate. People were asked for their feedback at their review. The feedback we saw was positive, with one person saying, "Staff don't gossip, respect my privacy and dignity and I feel safe with the staff."

A weekly bulletin was used to update the care staff on any changes in people's needs and reminders on good practice. For example information had been shared about communicating with people living with dementia, good hand hygiene, preventing dehydration, catheter care and a new performance management tool being introduced. This ensured staff were kept up to date with any changes within the service affecting their role. It also refreshed carers' knowledge and built upon the formal training they had already undertaken. Carers we spoke with all said they found the weekly bulletin informative and helpful.

The service had a formal complaints procedure in place. Three formal complaints had been received in the last 12 months. We saw they had all been responded to in a timely manner. Where the service was found to be at fault the response included an apology along what action would be taken to rectify the complaint.

People and relatives we spoke with were aware of how to raise a concern, saying they would contact the office; however, most said they had not had to do this. We were told that these concerns were usually addressed; however, one relative said that whilst the concern had been solved they had not received any communication from Absolute Care at Home about the issue. One person said they knew the people at the service's office who were usually able to answer any queries. This meant the service responded to issues raised, although didn't always communicate this to the person raising the concern.

When required the service supported people at the end of their life. Nursing support was led by the person's GP and the district nurse team. Changes in people's support needs were raised with the local funding authority to provide additional support for people at the end of their lives. This meant that where possible the service would support people to remain at home at the end of their lives.

Good

Is the service well-led?

Our findings

People and relatives we spoke with were positive about the service they received from Absolute Care at Home. Comments included, "We're happy with the agency, they do look after you" and "When I had to go to hospital I asked the social worker to re-start with Absolute Care at Home as I didn't want another agency." However one relative said the managers could be defensive at times when they asked for changes to be made to the care package.

People we visited said they would recommend Absolute Care at Home to other people, with one relative saying, "We've had poor care agencies in the past but since we started with this agency we've been much happier."

At our last inspection in April 2017 we found a breach of regulation 17 Good Governance due to the inconsistent medicines audits and the continued lack of capacity assessments. At this inspection we found improvements had been made and this regulation was now being met.

Each month the medicine administration records (MARs) and daily logs were reviewed by the senior support workers. This was now completed in a timely manner and there was a clear process for dealing with any missing signatures or issues found. A four-tier system had been developed to ensure staff learned from mistakes. For example, if a carer had not signed a MAR chart they would first be spoken to by a senior carer or the care co-ordinator. If this happened again with the same staff member an observed medication practice would be completed, followed by extra training and eventually disciplinary action. This meant there was a consistent approach and any gaps in the MARs sheets were investigated and steps taken to try to prevent re-occurrences.

As detailed in the effective domain of this report capacity assessments were now in place.

A care log review was completed for each person's care files every six months. This included reviewing the care plan, risk assessments and daily records. It also checked that staff were visiting people at regular times and staying for the allocated time. We saw that action was taken where needed following a care log review; for example, staff were contacted and reminded to make sure they attended calls at the agreed, specified times.

A training matrix was in place that highlighted when staff were due to complete any refresher training. This meant the service had time to organise the relevant training before it expired. We saw that the staff training was up to date.

The registered manager and care manager had an oversight of all accidents and incidents.

Senior carers also undertook unannounced spot checks on carers to monitor their time keeping, approach, appearance, that the care plan was read and signed and that the daily log records made were accurate. This also helped to oversee and improve the quality of care being provided where needed.

Management meetings were held every three months. These looked at any missed call logs, care plan and medication audits and staff development. The most recent management meeting held in February 2018 discussed the implications of the new General Data Protection legislation (GPDR) being introduced and how the company would ensure they complied with it.

This meant Absolute care at Home had a quality assurance system in place to monitor and improve the quality of the service.

Staff meeting were also occasionally held, although staff told us these could be difficult to attend if they were scheduled to be supporting people. Staff meetings were organised by runs so that carers who covered the same areas met together to discuss any issues or concerns in their area. Staff said that they were kept fully informed about the people they supported and the company through the weekly bulletin. Staff were positive about working for Absolute Care at Home. Staff members told us, "I have lots of support from the care co-ordinators and managers. If I'm unsure of anything I can always go to them; they are very approachable", "I can go to management for anything" and "If you have a problem they will listen and sort it out."

We saw that a survey had been completed in December 2017. The vast majority of forms returned stated that people were very happy with the service they were receiving. Where any issues or concerns were raised in the survey these were responded to and dealt with appropriately. Comments from the surveys included, "[staff name] is always on time and maintains a professional profile, they always enquire if there's any other ways they can help me. An asset to your company", "We are very happy with your service" and "I am really pleased with my carers and their caring attitude and professionalism."

Since our last inspection the service had concentrated the area covered to the Trafford area. The registered manager told us this was due to problems they had had recruiting staff in other areas and also managing the staff and travel times remotely. All the runs were now in the Trafford area which allowed seniors and managers in the office to be more closely in touch with their staff and staff were more easily able to visit the office location if required.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the Care Quality Commission (CQC). We checked the records at the service and found that all incidents had been recorded, investigated and reported appropriately.