Thorough Care Corporation Ltd

268 Ashingdon Road

Inspection report

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11 April 2018
16 April 2018
18 April 2018
20 April 2018

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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on the 11, 16, 18 and 20 April 2018 and was announced. We gave the registered provider 48 hours' notice to make sure someone was available in the office to meet with us.

This was our first inspection of the service since it was registered with the Care Quality Commission in May 2017. 268 Ashingdon Road is a domiciliary care agency that provides personal care and support to people living in their own homes. Most people using the service were older people with palliative care needs. There were seven people receiving a service at the time of our inspection.

At the time of inspection there was no registered manager in post. The registered provider had been the registered manager but had resigned from the position but was still actively involved in running the service. A new manager had been recruited who was going through the registration process. 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.

Risks to people had been assessed with guidance in place for staff on how to manage them. However, risks to people's home environments had not been adequately considered.

We made a recommendation about assessing risks in people's homes.

People's needs had been holistically assessed, however we found there was insufficient written guidance recorded in people's care records for staff to follow.

We have made a recommendation about the quality of information held in people's care records.

Staff training needs had not always been identified or training provided to ensure staff had the necessary skills and knowledge to meet people's needs. However, plans had been put in place to address this issue.

Staff had not received formal supervisions, annual appraisals or observations of their practice which help services to monitor staff performance and identify any learning needs. However, staff felt well supported and had access to informal and ad hoc support and advice as needed.

Where people had specific communication needs these had not always been assessed and recorded.

We have made a recommendation about inclusive communication practices.

Care plans were task-focussed and did not always contain sufficient information to support staff to provide individualised care.

We have made a recommendation about the provision of person-centred care.

Most people who used the service received palliative care and the service ensured they had access to treatment and support from health professionals to keep them comfortable and pain free. However, people's care records had not captured their wishes and preferences for their end of life care.

We have made a recommendation about end of life care planning.

The provider had not ensured that the quality and safety of the service was monitored robustly. Oversight of the service and staff team was not always sufficient to identify areas that required improvement.

We have made a recommendation about quality monitoring and oversight of the organisation and staff team.

There were sufficient numbers of staff who had been safely recruited to meet people's needs. Staff had been trained in how to safeguard adults from abuse and understood how to report concerns to keep people safe.

Medicines were safely managed as staff had received training from the provider who had checked to ensure staff were competent to administer people's medicines.

People were supported to have enough to eat and drink and maintain their health and wellbeing. People's consent to care had been sought and staff understood how to help people living with dementia make their own decisions.

Staff were kind and caring. People were supported to be as independent as possible by regular staff that knew them well and had formed positive relationships.

The culture within the service was open and transparent and staff and management held the shared vision of providing kind and compassionate care.

People and staff were included in the running of the service and feedback was actively sought to drive improvements.

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 sufficient staff employed who had been safely recruited to safely meet people's needs. Staff had received training in how to safeguard people from the risk of abuse. Risks to people had been assessed and staff showed a good awareness of the risks to people and knew how to keep people safe. However, risks in people's home environment had not been assessed. People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Care plans did not always provide sufficient guidance to staff on how to deliver effective care and support. The mechanisms for training, supervision, observations and appraisals of staff required strengthening. People were supported to have enough to eat and drink access to health services when needed. Staff supported people to make their own decisions and choices.

Is the service caring?

Good

The service was caring. Staff were kind and caring and had formed positive relationships with people. People were treated with dignity and respect and their independence was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's wishes and preferences were not always identified, however staff knew people well and adopted a person-centred approach. There were systems in place to respond to complaints. People received support to remain comfortable and

pain free to meet their end of their life needs however improvements were required to ensure people's preferences were recorded and respected.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Improvements were required to ensure more robust oversight of the service and the staff team. There were plans to develop the service but these had not yet been put in place. Staff felt well supported and the culture within the service was open and transparent. People and staff were included in the running of the service and feedback was actively sought and acted upon.

268 Ashingdon Road

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.

Prior to the inspection visit we telephoned the relatives of five people who used the service on 11 April 2018. The telephone interviews were conducted by an expert by experience. An expert by experience is a person who has experience of using this kind of service. The inspection visit to the service's office was carried out by one inspector and took place on 16 April 2018 and was announced. We gave the provider 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. After our site visit we made telephone calls on the 18 and 20 April 2018 to interview three members of staff. We also contacted three health professionals who worked in partnership with the service.

Before the inspection visit we checked the information that we held about the service including statutory notifications. A statutory notification is information about important events which the provider is required to tell us about by law. During our visit to the office we spoke with the provider and the new manager who was currently going through the registration process. We looked at documentation which included five people's care records, four staff files and records relating to the management of the service.

Good

Is the service safe?

Our findings

People and relatives said they felt safe using the service. One relative told us, "I am confident that [named person] is safe in the hands of the carers; just their manner and attitudes enables me to relax when they are here." People received care and support from regular care staff who wore ID badges and uniforms and relatives told us that if new staff visited to provide care and support, they were always introduced to them first. All of which helped people to feel safe.

Staff had received training in how to safeguard people from the risk of abuse. Staff were aware of the signs to look for that someone was being abused and knew how to report any concerns to keep people safe. The provider and manager were aware of their safeguarding responsibilities which included notifying CQC and the local authority of any safeguarding concerns. The service had a whistle-blowing policy in place which sets out what staff should do if they have any concerns regarding the behaviour or attitude of other staff or the organisation they work for. Staff confirmed that they had read the policy and would feel confident to whistle-blow if required.

Individual risks to people had been assessed and these assessments were updated when people's needs changed. Lessons had been learned and the provider had changed their system for recording information about people's current needs from handwritten to typed notes. The provider told us that in the past they had sometimes struggled to find the most up to date information about people's care needs which meant staff might miss important information. The provider had also improved the quality of their risk assessments to ensure there was sufficient guidance for staff in people's care records on how to manage risks. Staff we spoke with were aware of the risks to people and how to manage them. For example, one staff member told us, "[named person] is at risk of choking, we know not to give them food and drink as this is provided by their family." When people's needs changed, this information was shared with staff so that they always had the most up to date information on how to support people to stay safe.

Whilst individual risks to people had been assessed, we found that risks in people's home premises had not been formally assessed and recorded. We discussed our concerns with the provider who acknowledged that this was an issue that needed to be addressed.

We recommend that the provider reviews their current assessment process to include an assessment of risks to people and staff with regard to the living environment where care and support is provided.

At the time of inspection only one person required support with administering their medicines. The provider, who was a registered nurse, initially administered medicines whilst training staff to take over the role. Staff were assessed by the provider as competent before they started to give people their medicines. Medicine administration records (MARs) were in place which staff signed to evidence that they had given people their medicines. The provider had added a stock count sheet to the person's care records which provided an additional means of checking that people's medicines were being managed safely. This sheet was completed by staff every time they administered medicines and was also double checked by the provider to monitor that people were receiving their medicines as prescribed.

Safe recruitment practices were followed before staff were employed to work with people. Staff files included application forms, records of interview and references which had been verified by the provider to ensure they were valid. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure new staff were suitable to work with vulnerable adults. The necessary checks had all been completed prior to staff commencing employment.

We looked at the staff rota and saw that there were sufficient staff deployed to safely meet people's needs. People and relatives told us that they had never received a missed call. We were told that staff were usually on time and that people normally received a phone call if staff were going to be late. One relative told us, "The girls always come on time and have a smile on their face." People told us staff were not rushed and staff we spoke with confirmed that they had enough time to spend with people.

There were systems and processes in place for reporting accidents and incidents and staff were aware of the procedures. However, at the time of inspection there had been none to report.

Staff had received training in infection control and followed good practice guidelines. The service provided staff with protective equipment such as aprons and gloves to support staff to prevent the spread of infection.

Requires Improvement

Is the service effective?

Our findings

When people joined the service the provider completed an initial assessment which identified people's physical, mental health and emotional needs. The information collected was used to write the person's care plan. Staff told us that they read this assessment for guidance on how to support people when they visited them for the first time. However, we found that the information recorded in people's care plans lacked detail and provided insufficient guidance for staff to follow. For example, one person was identified as having behavioural issues. Staff were reminded to be vigilant and avoid positions where they put themselves at risk. However, there was no information on what situations would put staff at risk and no guidance as to possible triggers for the behaviours and how to diffuse potential escalations of aggressive behaviour.

We discussed our concerns with the provider who acknowledged that the level of detail in people's individual care plans could be improved upon.

We recommend that the service reviews its current practice to ensure that people's care records contain sufficient guidance on people's individual needs to support staff to consistently provide effective care and support.

When new staff joined the service they received an induction which involved reading the company's policies and procedures. New staff then spent a week working alongside the provider getting to know people. During this time the provider observed their practice and assessed their competence before signing them off as competent to work unsupervised. Staff then spent a further week working with an experienced member of staff before working independently. People told us that they thought the staff were well trained and competent in their job role. A relative told us, "The girls who look after [family member] seem really well trained." Another said, "I think all the girls who come know what they are doing."

At the time of inspection there were four staff working at the service. Two of the staff members who had previously worked in care had been provided with on-line training to support them in their role. This covered subjects which were relevant to the people they supported, for example, food hygiene, infection control and dementia awareness. Manual handling training had also been provided to the two staff members but this had also been delivered online. This is not considered best practice given the practical nature of the task of moving and positioning people.

The two newest members of staff, who had not worked in care before had only received the online training which was included in the Care Certificate. The Care certificate represents a set of standards care workers should apply in their daily practice. Whilst the care certificate is recognised as best practice when inducting new staff into the social care sector it does not equip staff with all of the necessary knowledge and skills required to deliver effective care and support. For example, manual handling training is not included as part of the care certificate standards.

At the time of inspection we found that the lack of formal training in manual handling had not impacted on people who used the service as only one person required hoisting using a ceiling hoist. All of the staff we

spoke with confirmed that they had been shown how to use this equipment and had been assessed as competent by the provider before completing any manual handling tasks independently. Whilst we were assured that the provider had the practical skills and experience to support staff with manual handling tasks, they were not a qualified trainer. We therefore felt there was the potential for risk, given the lack of formal and quality training should new people join the service in the future with more complex manual handling needs.

We discussed our concerns with the provider who told us they thought manual handling training was included in the care certificate. The provider assured us the issue would be immediately addressed as they would organise for the new manager to complete a 'train the trainer' qualification in manual handling to ensure that staff had the necessary skills and competence to move and position people safely. After our inspection we received confirmation that this training had been booked for May 2018.

During the inspection we also found that there were no formal systems in place to provide supervision, observations of practice and annual appraisals, all of which are used to provide support to staff and aid their professional development. Nonetheless, staff told us they felt well supported and sometimes worked alongside the provider so received informal supervision and appraisal of their practice. One staff member told us, "I feel very supported if I have a problem I can go to the office and have a chat anytime; you can always get hold of someone on the telephone and if they are busy they will always call you straight back."

We discussed our findings with the management team regarding the lack of a structured supervision, observation and appraisal process which would become more of an issue if the company were to grow. The provider told us that they sometimes worked alongside staff providing care and support so had the opportunity to monitor and support staff however this was not recorded. We were advised that there were plans to provide formal supervision, spot checks and annual appraisals in the future once the manager had settled in and the staff team had been fully established.

We recommend that formal systems and processes are put in place to support staff learning and development and monitor performance to ensure staff continue to meet people's needs safely and effectively.

Staff had received training in food hygiene and when required, provided support to people with eating and drinking. Where it was identified that people were at risk of becoming dehydrated or malnourished, the provider had introduced food and fluid charts to monitor the amounts people ate and drank. If a deterioration in people's food or fluid intake was noted this information was shared with health professionals to ensure people received any additional support or treatment they required.

People's health needs were identified during their initial assessment. The provider worked closely with community health professionals and the clinical commissioning group (CCG) to share information when people's health deteriorated and secure additional support. We received feedback from the CCG that they had no current concerns with the service being provided by 268 Ashingdon Road. However, we did find that people did not have care plans or risk assessments in place for their specific health conditions. This meant that staff did not have access to written guidance on how to manage people's particular health needs or information about the signs and symptoms to look for that could indicate that a person's health was failing and how to respond to this. The risks associated with this lack of guidance was minimised due to the fact that the provider (a qualified nurse) visited people twice a week to monitor their health and wellbeing. However, there was the potential risk of a person's health deteriorating in the interim and this not being picked up by care staff that did not have the same depth of clinical knowledge and expertise as the provider.

We therefore recommend that the service reviews its current system for recording information relating to people's health conditions to ensure all staff have access to sufficient guidance to effectively meet people's health needs.

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.

Staff had received training in the Mental Capacity Act 2005 and staff we spoke with had a good understanding of how to apply the principles of the Act in practice to support people to make decisions. Staff understood the importance of assessing whether a person could make a decision and the steps they should take to support decision-making, for example, presenting information in a way that people could understand and giving people the time and the space to process information. One staff member told us, "You give people a choice, let them try things. Look for positive reactions like smiles, gestures and facial expressions." Staff understood the importance of gaining consent from people before providing care and support. One staff member explained, "I always greet people nicely explain what I am doing, if people struggle with consent I look for them to nod or smile to indicate that they are giving permission." Relatives confirmed that staff asked their family members for consent before providing care and support. A relative told us, "I can hear the girls asking if it is ok to do things for him."

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and caring. One person told us, "We couldn't ask for better care I am very happy with all that they do for both of us." Another said, "The girls who come to us really care, it's not just a job to them."

People's communication needs had been assessed and recorded to provide guidance for staff. However, the information in some people's care records lacked detail and there was evidence of an inconsistent approach. For example, one person's care records stated, "[named person] cannot verbally express their needs; they do respond to people speaking with them; gestural prompts recommended." However another person's care records simply stated "non-verbal" with no other information for staff regarding any alternative methods such as interpreting the person's behaviour to support communication. This demonstrated a lack of consideration of people's specific communication needs and how best to support people to express themselves.

We discussed our concerns with the provider and manager who agreed that a more detailed and person-centred approach was required to ensure people were supported to communicate their needs and wishes as far as they were able.

We recommend that the provider review its current method of assessing and recording people's communication needs to support staff to employ the most suitable means of communication so that people are fully included in discussions about their care and support.

Staff told us that because they saw people regularly they knew the people they cared for well. One staff member said, "We go to the same people every day so we get to know them; over time we have built up relationships with people." Relatives confirmed that staff had formed positive relationships with their family members.

Relatives told us their family members were treated with dignity and respect by staff. One relative told us, "They [staff] do everything that needs to be done in a respectful way." Staff demonstrated that they understood how to protect people's dignity and privacy when providing personal care to people. One staff member told us, "If I am washing someone, I only reveal the bit I am doing and keep the other half covered; I also make sure the doors and curtains are closed." All of the people and relatives we spoke with confirmed that staff maintained people's privacy and dignity when personal care was being given. One relative told us, "I am confident that [named person's] dignity is maintained at all times by the staff." Another relative said, "The girls always draw the bedroom curtains when they do anything for [named person] even though no one can see in."

The service supported people to be independent. Relatives told us that staff encouraged their family members to be as independent as they could be according to how they felt on a daily basis. We were told that care staff never left until people were comfortable and had all they needed until the next visit.

We looked at how the service recognised equality and diversity and protected people's human rights. Care records captured key information about people including any personal and religious beliefs. We saw that people who used the service could request a preference of gender of care worker and this was respected to help people feel comfortable and at ease with receiving care and support.

To strengthen its approach to equality, diversity and human rights, we recommend the provider consults the CQC's public website for further guidance entitled 'Equally outstanding: Equality and human rights – good practice resource.'

Requires Improvement

Is the service responsive?

Our findings

The service involved people in planning their care and support. When new people joined the service they met with the provider who completed an initial assessment where people's needs and abilities were recorded. This information formed people's care plans which were then reviewed on an on going basis as their needs changed. People and relatives told us that they were included in planning their care. A relative told us, "We filled in the care plan at the start and if anything changes it's altered accordingly." We saw consent forms had been signed by people or their relatives indicating that people had been included in the care planning process.

We looked at five people's care plans and found whilst they held some basic information about people's likes and dislikes, the care plans were task focussed, which means they focussed on describing the tasks care staff should complete, for example, "assist with washing, breakfast and bed-making." There was a lack of meaningful information about people's life history, wishes, preferences and preferred routines. This type of information helps staff provide care that is person-centred. Person-centred care means care tailored to meet each individuals needs in a personalised way. However, despite the task-focussed nature of people's written care records, in practice staff were able to demonstrate that they understood the importance of providing people with person-centred care. One staff member told us, "It's about putting the person at the centre of the care; organising the care around what they prefer; for example, some people want their breakfast before a wash and some afterwards." Staff maintained daily records of the support that people received each day. We reviewed people's daily notes and saw that the care provided was responsive to each person's individual needs.

We discussed our findings with the provider and manager who told us that they would review people's care records to include more detailed and personalised information about people to reflect a more person-centred approach.

There were systems and processes in place to manage complaints. However, at the time of inspection there had been no complaints made about the service. All of the people we spoke with told us they were satisfied with the service they were receiving. One person told us, "When we first started having care we were asked what we felt we wanted from the company and they really seem to be delivering it." People were provided with information on how to make a complaint and told us they knew how to make a complaint if necessary. One person told us, "I do know how to complain but I can never imagine having to."

The service provided care to people at the end of their life. However, we found that people's preferences and choices for their end of life care had not been formally recorded. In addition only two of the four staff working at the service had received training in end of life care. This meant that staff had not been provided with the necessary training and guidance to support them to provide personalised end of life care. That said, because the service was small with a high level of daily oversight by the provider (a registered nurse), we found that in practice people were receiving good end of life care. We saw that the provider worked in partnership with community health professionals to support people with palliative care needs to remain comfortable and pain free. Any changes in people's conditions were promptly identified and communicated

to the relevant health professionals. This ensured that people had timely access to any support, equipment or medicines they required. Relatives confirmed they were confident that, with the continued support of care staff, their family members would be able to stay at home in accordance with their wishes.

We discussed our findings regarding omission of an end of life care plan for people. The provider told us that they recognised that this was an area that needed strengthening.

We recommend that the provider review their care planning process to ensure that people's preferences and choices for their end of life care are clearly recorded, regularly reviewed and upheld.

Requires Improvement

Is the service well-led?

Our findings

At the time of inspection a new manager had just been recruited who was going through the registration process. They were supported by the provider who was previously the registered manager. Together the provider and manager were responsible for the day to day management and oversight of the service.

The provider took a hands-on approach and would provide care and support to people to cover for staff absence when needed. The provider monitored the quality and safety of the service on an informal and ad hoc basis whilst out visiting people. The provider told us that they saw everyone who used the service at least twice a week. During their visits they checked people's daily care records to make sure people had received the appropriate level of care and support at the agreed times and duration. The provider also checked people's medicine administration records (MARs) and obtained feedback from people about whether they were happy with the service. However, these checks had not been documented and there were no recorded action plans in place to drive improvements within the service. In addition, whilst the provider demonstrated good oversight of people who used the service, this same level of oversight did not always extend to staff. For example, the provider lacked awareness regarding the training needs of some staff and staff had not received formal observations, spot checks or supervisions to check their performance and identify any learning needs.

We discussed our concerns with the provider and manager who understood that some improvements were needed to ensure the safety and quality of the service, including ways in which the knowledge and skills of staff could be fully and reliably monitored.

We recommend that the service review their current systems and processes for quality assurance and monitoring of staff performance to ensure more robust oversight of the service.

People, relatives and staff were positive about the provider. One person told us, "I am confident that if we had any problems that they would be sorted straight away." A staff member told us, "I think [provider] is an excellent leader; anytime I need something they are there; if I cannot reach them then they will immediately call me back." People and staff were not able to comment on the qualities of the manager as they had only just been recruited. However, all of the people and staff we spoke with were aware that a new manager had recently been appointed. Each person had been visited by the new manager to introduce themselves so that people would know who they were dealing with when they contacted the office. This demonstrated a commitment by the service to being open and transparent with people.

There was a positive culture within the service. Feedback from people and relatives confirmed that staff demonstrated positive values and attitudes including kindness, compassion, dignity and respect for people. Staff enjoyed working for the company and felt well supported by the provider who was hands-on and visible within the service. Regular team meetings had been organised so that staff were included in the development of the organisation. We looked at minutes of meetings and saw that the provider had listened and responded positively to feedback. For example, when staff had commented that they were not happy with the uniform, this had been changed.

People were also included in how the service was run and their opinions were invited. Telephone calls were conducted every two weeks by an independent person to check that people were satisfied with their care and support. The provider also sent out a satisfaction survey a week after people joined the service so they could provide feedback and any changes requested could be made. We found that the provider had responded positively to people's feedback and had made the necessary changes or improvements. For example, when people were not satisfied with their visit times these had been adjusted to fit in with people's lives.