Assured Care Southport Limited

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Inspection report

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Tel: 08001412776

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17 September 2018

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection took place on 11 and 17 September 2018 and was announced. We visited the registered office on 11 September and made phone calls to people who had consented to a phone call on 17 September 2018.

At the time of our inspection the service was providing small packages of care to 67 people and employed 33 staff.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community [and specialist housing]. It provides a service to older adults and younger disabled adults.

This was the registered providers first inspection due to a change of legal entity in 2017.

There was a registered manager in post.

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.

Staff were able to describe the process they would follow to report actual or potential abuse and this mostly consisted of reporting the abuse to the line manager. The service had a safeguarding policy in place and staff told us they were aware of the policy. Safeguarding training took place as part of the induction for new staff and was refreshed every year.

Staff recruitment records showed that staff were safely recruited after a series of checks were undertaken on their character and work history. We discussed at the time that some of files viewed would benefit from more detail being in place with regards to employment history.

Risk assessments were in place and were reviewed regularly or when people's needs changed. These contained basic details of how to support the person appropriately, while mitigating risk. They were instructive and clear however, were not personalised in their presentation, which was something the registered manager had identified themselves and were working towards.

Staff were supplied with personal protective equipment (PPE). This included gloves, aprons and hand sanitizer. Staff told us they were always able to ask for more PPE when needed. Staff had completed infection control and prevention training, and understood the importance of reporting outbreaks of influenza and vomiting to the manager, so they could cover their work so as not to spread the infection.

People were supported with their medication in accordance with their assessed needs and in line with recent guidance.

The registered manager and the staff understood the principles of the Mental Capacity Act 2005 and associated legislation. Some information in care plans with regards to the MCA and consent and best interests required some further development to ensure a consistent approach. We have made a recommendation concerning this.

Staff undertook training in accordance with the registered providers training policy. Staff told us they enjoyed the training. Staff spoken with confirmed they had regular supervision and appraisal.

People were supported as part of their assessed care needs with eating and drinking and staff were aware of people's preferences.

Additional role specific training took place to help people manage their support needs. The service had recently branched out into offering their own in-house training in partnership with a registered trainer.

Staff supported people to access other healthcare professionals such as GP's and District Nurses if they felt unwell.

People told us that the carers who visited were all very caring and would always ask them how they were feeling and ask them what they would like help with.

People were complimentary about the caring nature of the staff, and the registered manager, who often completed care calls themselves.

People told us that they were always kept informed and involved in their care.

We did not observe care being delivered, however, people told us staff were kind and caring in their approach.

Information in care plans was regularly reviewed and updated in line with people's needs. This meant that the registered provider was responsive to people's needs and preferences. Care plans contained some detailed information about people, what their preferences were and how they liked their care to be conducted, however, we did raise that some information would benefit from being more personalised.

Complaints were investigated in line with the complaints procedure and responded to appropriately. There had been no complaints recorded.

Audits took place which checked service provision and action plans were implemented to improve practice.

Feedback was gathered from people using the service, however this had not been done for some time. The registered provider assured us they would send the feedback forms out by the end of the month. Feedback was conducted every few months over the telephone, and annual audits were due to be completed.

Team meetings took place and minutes were available.

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.

People received their medications on time.

Risks to people were assessed, and there was information with regards to how to manage the risk to people. Some of this information was quite basic, which we discussed at the time with the registered manager.

People told us they felt safe receiving care from Assured Care.

Staff recruitment was mostly robust, however we did highlight some areas which required further information.

Is the service effective?

Requires Improvement

The service was not always effective.

Information around capacity, decision making and consent was not always clear and consistent in care plans viewed. We have made a recommendation about this.

Staff had the correct skills and knowledge and undertook training relevant to their roles.

People were supported with their meal preparation in line with their assessed needs.

Is the service caring?

Good

The service was caring.

People told us staff were kind, caring and treated them with dignity and respect.

People's preferences were reflected throughout care plans. This helped staff to get to know people and provide care based on their needs and preferences.

Staff spoke fondly about people, and described how they respected people's dignity.

Is the service responsive?

Good

The service was responsive.

We received positive information regarding the complaints process, people we spoke with said they knew how to complain.

Care plans contained person centred information about people's likes, dislikes and how they preferred their care to be delivered.

There was evidence that staff support people in a way which respected their diverse choices.

Is the service well-led?

Good

The service was well-led.

There were polices and procedure in place for staff to follow.

The registered manager was aware of their role and had reported all incidents to the CQC as required.

People and staff told us they liked the registered manager and knew them by name.

There was regular auditing taking place of care files, medication and other documentation relating to the running of the service.

Assured Care Southport

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 inspection started on 11 September 2018. This is when we visited the registered office to speak with the registered manager and to review documentation. We made phone calls to people who used the service and staff on 17 September 2018.

The inspection was announced. The provider was given 48 hours' notice as the service provides domiciliary care, and we wanted to be sure staff and people who used the service gave consent for phone calls and would be available to speak with us.

The inspection was conducted by an adult social care inspector.

Before our inspection visit, we reviewed the information we held about Assured Care. This included looking at the notifications we had received from the provider about any incidents that may have impacted on the health, safety and welfare of people who used the service. We did not have a Provider Information Return (PIR) for this service. This is because one was not requested by us. This form asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. Additionally, we approached local stakeholders for feedback about the service. We received no responses. We used this information to help us populate our 'planning tool' which determines how the inspection should be carried out.

We spoke to one person who used the service and five relatives. We spoke with five staff, the registered manager and registered provider. We looked at the care plans belonging to four people and other related records. We checked the recruitment files for four staff. We also looked at other documentation associated with the running of the service.

Good

Is the service safe?

Our findings

People who were using the service and their relatives said they received a safe and consistent service. Some of the comments we received included, "They are spot on." "My staff always come on time." "I have absolutely no complaints with the service." "I know that my relative is well taken care of."

We looked at how staff rotas were managed by the service. We saw that people's call times were adequately spaced, with 15 minutes built either side of the call to allow for travel time in between calls for staff to get to and from people's homes on time. Staff told us that they were happy with their rotas and they mostly visited the same people. This meant that staff were able to develop relationships with people, and offered consistency for people that received care.

We discussed the procedure for Electronic Call Monitoring (ECM) with the registered manager. ECM is a technology where carers 'sign in' to their calls either using a smartphone or the person's home telephone. The registered manager and registered provider did say this would be considered as the area grows. The service currently ensures staff arrive at their calls either by making random out of hours calls to people's homes, or depending on family members or life line to let them know.

We saw that there had been no missed visits in the last 12 months.

Staff were able to explain the course of action that they would take if they felt someone was being harmed or abused. Staff said they would 'whistle blow' to external organisations such as CQC if they felt they needed to. Staff had received training in safeguarding and their responses were in line with procedures set out in the service's safeguarding policies. This stated that staff should report all potential abuse to the appropriate authorities. Information regarding safeguarding for people who used the service and relatives was readily available within the service user guide and the office. People confirmed they knew how to raise concerns should they have any.

Care records included reference to any follow up actions that were needed following any accidents and incidents. Accidents and incidents were accurately recorded and were reviewed by the registered manager in order to identify any patterns and triggers. This meant that the registered manager was overseeing if trends were being established and how to safely manage risks.

We checked to see how the administration of medication was being managed at the service. People's medications were stored in their own homes. We saw that reasons for people self-medicating or not, were clearly documented. People prescribed PRN (medication when required) had a detailed protocol in place which explained when the PRN was needed and why. Staff recorded their signatures in Medication Administration Records (MARs) when they had helped someone take their medication. There was also a list of all medications the person was taking within their care plans. This meant that staff knew what medication each person took and what it was used for. We saw that one person was supported to take their own medication. The service had assessed that the person was able to do this if the medication was packaged in a different way, as they sometimes struggled with certain packaging and boxes. The service arranged for the

person's medication to be packaged differently to enable them to continue to self-medicate and maintain their independence.

The registered manager completed risk assessments to assess and monitor people's health and safety. There were risk assessments and management plans in place for falls, manual handling, pressure care and nutrition. Each care plan contained risk assessments which showed the relevant risks, control measures and how to mitigate the associated risks.

Risk assessments were basic in the level of detail and were generic in nature. For example, risks regarding moving and handling were assessed and an explanation recorded with regards to how to mitigate risk, however, there was no further detail which made the risk assessment specific for that person. We discussed this with the registered manager, who had identified themselves in a recent audit that some risk assessments required further personalised information such as what people liked staff do to support them mitigate the risk. The registered manager had a plan in place for the few weeks to review everyone's risk assessments to make sure more personalised information was recorded.

Each care file contained an environmental risk assessment. This had been completed at each person's home during the initial assessment process to highlight any potential hazardous working conditions for staff such as pets or stairs. Action had been taken to minimise risk to both staff and the person they supported.

We reviewed four personnel files of staff who worked at the service and saw there were safe recruitment processes in place including; photo identification, employment history, two references and Disclosure and Barring Service (DBS) checks. DBS checks are carried out to ensure that staff are suitable to work with vulnerable adults in health and social care environments. There were some gaps in the recording of staff members past employment, we discussed this at the time with the registered manager and they took action to rectify this.

Staff were supplied with personal protective equipment (PPE). This included gloves, aprons and hand sanitizer. Staff told us they were always able to ask for more PPE when needed. Staff had completed infection control and prevention training, and understood the importance of reporting outbreaks of influenza and vomiting to the registered manager, so they could cover their work so as not to spread the infection.

Requires Improvement

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.

We checked the processes for assessing people's capacity and gaining consent. We saw that some information concerning people's capacity was confusing. For example, one person was described as having capacity. However, when we looked at some of their other documentation there was conflicting information around the person's decision-making ability, and what support they required to make certain decisions. This meant that we could not be sure that their capacity was considered when care plans were completed. We also saw that some care plans had not been signed by people, so we were not sure if they were able to consent to their care or if this would need to be a best interest decision. Staff and the registered manager indicated that they understood the principles of the MCA and everyone confirmed that staff asked for consent before they provided care. However, some information in people's care plans around capacity and consent required improving so it was more consistent.

We recommend the provider reviews their processes relating to the MCA and consent, and takes action accordingly.

We received the following comments in relation to the staff skills and training. "I feel the staff are well trained." "Yes they know what they are doing."

We viewed the training matrix in place for the staff. We saw that staff had completed their mandatory training and some were booked to attend training refreshers in the next few weeks. Training was a mixture of e-learning and practical sessions, for manual handling and medication. Staff were also required to complete a competency assessment to ensure they were able to administer medication, this was signed by a senior member of staff. We checked certificates for staff training courses attended against the training matrix and found that the dates matched for the courses attended. This meant that staff training was up to date. The registered provider told us they were changing their approach to training. They had recently developed a partnership with a local training company and were in the process of assigning staff to the first training session.

New staff were inducted in accordance with the principles of the Care Certificate. The Care Certificate requires staff to complete a programme of learning and have their competency assessed before working independently. Staff attended formal supervisions every eight weeks, and received an annual appraisal.

We saw that people had been pre-assessed before their care package commenced. Some people required temporary care packages to be out in place following a hospital admission. This is often referred to 'reablement care packages'. Following an initial six weeks of support from Assured care, people had either

recovered enough to not require support, or chose to keep the support going. This demonstrated that the service was working effectively with other services such as social workers, to ensure people were supported in the best way possible.

People we spoke with and their relatives told us that the staff helped them prepare their meals in accordance with their needs and wishes. One person said, "The staff always make sure that I have eaten". A relative told us, "I know that they [staff] will let us know if [family member] did not each much."

People said staff will offer to call the GP on their behalf if they felt unwell. Each person had contact details for their GP and pharmacy in the front of their care plans. This meant that staff were supporting people with their medical needs and appointments when needed.

Good

Is the service caring?

Our findings

We received the followed comments about the caring nature of the staff and the service as a whole. Some of the comments we received from people included, "They are excellent", "No complaints from me." "Lovely bunch." "Smashing lot."

Everyone said they would recommend the company based the caring nature of the staff.

Staff talked fondly about people, and described how they ensured people's dignity was respected. One staff member said, "I make sure I knock on the door and say hello." " I would never share the key safe numbers with anyone."

We asked people about the need to respect privacy and dignity. People told us that staff respected their right to privacy and were mindful of this when providing personal care. For example, we saw that one person required staff to ensure the battery on their hearing aid was regularly checked to ensure that they could always communicate with the staff during personal care calls.

Staff had received training in relation to quality and diversity and the provider had an equality and diversity policy in place. Equality and diversity considerations were written into people's care plan, and we saw some good examples of this, for example, one care file documented; 'Please ensure you say hello and goodbye to (person), they like this.'

We received mixed comments from people with regards to gender choice of their carer. However, people also said that this did not bother them.

Even though care plans we viewed did not always contain signatures of the people who used the service, people told us they were involved in their care plans. One person said, "Yes I think that the care paperwork was discussed with me."

There was no one accessing advocacy service at the time of our inspection, however there was information available in the service user guide with regards to local advocacy agencies.

It was clear from discussions that staff knew the people they supported well. When we spoke with staff they described their roles and how they were expected to support people with their needs in detailed, positive terms. Staff we spoke with said they enjoyed their jobs and told us they liked the fact that they visited the same people.

People told us that staff would do things that were out of their remit, such as help them put their washing away, and bring them newspapers from the local shops.

Good

Is the service responsive?

Our findings

Care plans contained information around people's needs which was person centred. Person centred means based around the needs of the person and not the service.

There was a description with regards to what to do on each call for the staff to adhere to, which had been requested by the person in receipt of the support. For example, we saw information recorded such as, 'please ensure my thermostat is turned to 20 degrees before you go.'; Additionally, in another person's care plan we saw information around what drink they liked before bed, and the staff to ensure they closed curtains and blinds. Also, one person whom staff supported to apply cream, preferred staff to wash their old cream off before applying new cream. This was clearly recorded in the person's care plan.

We did raise, however, at the time of the inspection that some of the care plans would benefit from having more information recorded with regards to people's backgrounds and personalities. The registered manager informed us that they would take this on board and include this information when they next reviewed people's care plans.

Equality and diversity support needs were assessed from the outset. Protected characteristics (characteristics which are protected from discrimination) were considered at the initial assessment stage and included age, religion, gender and medical conditions/disabilities. This meant that the registered provider was assessing all areas of care which needed to be supported and established how such areas of care needed to be appropriately managed. For example, ensuing that one person who has deaf, had their hearing aids next to them at all times so they could hear the phone ring or the door bell.

Staff were trained in end of life care. People were supported to remain at home if they wished, supported by staff and other medical professionals. People had information in their care plans regarding what arrangements would be needed in the event of their death. The service had recorded and responded to people's deaths appropriately and sensitively.

People and their relatives told us they were aware how to make a complaint and they would have no problem in raising any issues. There had been no recorded complaints. The policy contained details of the Local Authorities safeguarding procedures as well as the contact details for the Local Government Ombudsman (LGO) if people wished to escalate their complaint.

Good

Is the service well-led?

Our findings

There was a registered manager in post who had been involved with the service for a number of years.

People said they liked the registered manager and knew them by name. Staff said they liked working for the service and people said they would recommend the service to other people.

Team meetings took place every few weeks and we saw some of the minutes for these. Agenda items included safeguarding, training, and recruitment. For staff that did not attend meetings minutes were available for them to access.

The service had policies and guidance for staff regarding safeguarding, whistle blowing, MCA, compassion, dignity, equality and diversity medication and safeguarding which we reviewed during this inspection. .

The registered manager discussed lessons they had learnt from looking at the quality of their own training and training that was available locally. The registered provider spoke to us at length about the development of a new training programme which they would make available to all care workers which was more detailed and structured, and encompassed classroom based learning as some staff had fed back they did not like e-learning.

People we spoke with told us they had been contacted by the service regularly to ask for feedback, and they were always asked if any improvements were required to their care package. Contact sheets were completed every day with regards to feedback form people who received support from Assured care.

There was a formal mechanism to gather feedback, however the registered manager was transparent about the fact that they had not sent these out yet, however they assured us they would do this in the next few weeks.

We looked at the quality assurance systems and processes to monitor how the service was operating and to drive forward improvements. A range of audits and checks were undertaken. The registered manger completed a management audit each month. Additionally, telephone feedback was gathered, as well as weekly spot checks on the support provision. This ensure that the registered manager is checking staff were delivering care in accordance with the requirements of the package. We saw any issues which had been highlighted had been action planned and discussed in staff supervision or team meetings.

Other audits took place in areas such as care files, staff training and medication.

The service worked well with the local authority, and tried to accommodate packages of care at short notice to enable people to return home after a prolonged stay in hospital.

The registered manager was aware what was required to be reported to CQC by law. As this was the services first inspection under the new provider's registration there were no requirements for previous ratings to be

displayed.