Amegreen Complex Homecare Limited

Amegreen Complex Homecare - Buckinghamshire

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 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 older adults, younger disabled adults, and children.

This announced inspection took place on 30th April and 1 May 2018. There was a registered manager in place. 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.

This was the first inspection since the provider moved locations in February 2017.

People and their relatives told us they believed the service was safe. Risk assessments had been completed for care and the environment. We found some areas of the administration and recording of medicines needed reviewing. We have made a recommendation about this in the report.

Care plans gave guidance to staff on how to reduce risk and included people's needs and preferences. People's needs were assessed prior to receiving care. Where possible people or their relatives where involved in the selection process of staff.

Staff received an induction which included training. They received support through supervision and appraisals. Specialist training was provided to ensure they could meet people's individual needs. Competency assessments took place to ensure staff where meeting the required level of skills and knowledge. Where staff failed to meet the required standard, action was taken by the provider.

Safe recruitment systems were in place to minimise the risk of unsafe staff being employed within the service. Staff understood the indicators of abuse and how to report their concerns.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

People's healthcare needs were met through the involvement of external professionals and the cooperation of Amegreen staff. Guidance was documented in care plans and practice was carried out in alignment with the suggested advice.

Staff were deemed to be caring. The majority of people and their relatives spoke positively about the staff attitude and caring nature. People's protected characteristics were supported by staff. People received support to participate in their chosen lifestyle.

Where people had communication difficulties, staff were trained to ensure their ability to communicate was

enhanced. People were assisted to remain as independent as possible and staff understood how to protect people's privacy and dignity.

There were mixed responses regarding the effectiveness of the management of the service. Where people had raised concerns these had either been dealt with or were in the process of being managed. The provider was responsive to complaints and used the learning to improve the quality of the service. They were aware of the weaknesses in the service and had taken action to strengthen them.
We have made a recommendation about the duty of candour requirements. This was due to the fact the registered manager had limited knowledge about this regulation. However their practices were in line with the regulation.

The registered manager was a member of a number of accredited associations, which enabled them to keep up to date with best practice.

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 were protected from the risks of abuse as staff were suitably trained and policies were in place to safeguard people.

Risks were identified and minimised. Risks were kept under constant review in order to keep people safe. This reduced the risk of people receiving inappropriate and unsafe care.

Is the service effective?

Good

The service was effective.

People were encouraged to make decisions about their care and day to day lives. Decisions made on behalf of people who lacked capacity were made in accordance with the Mental Capacity Act 2005.

People's health was monitored and when necessary external professionals were contacted to provide support to people on maintaining good health.

Is the service caring?

Good

The service was caring.

People were supported by staff who demonstrated a caring nature and who were knowledgeable about people's needs and the care required.

Peoples' dignity and privacy was respected and promoted.

Is the service responsive?

Good

The service was responsive .

People participated in activities at home and in the wider community. This encouraged inclusion and protected people from social isolation.

The service a system for receiving; recording; handling and

responding to complaints. Complaints were used as a tool for driving forward improvements to the service.

Is the service well-led?

Good

The service was well led.

Staff told us the management were supportive and they worked well as a team. There was an open and honest culture which enabled good communication and a positive working environment.

Systems were in place to assess; monitor and improve the quality and safety of 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was announced. We gave the service 48 hours' notice to ensure someone would be available to assist us with the inspection. On 27 April 2018 we contacted people who used the service or their relatives by telephone to receive feedback . We visited the office location on 30 April 2018 and ended on 1 May 2018 to see the manager and office staff; and to review care records and policies and procedures. We contacted professionals by email who had knowledge of the service.

An expert by experience carried out the telephone calls to people or their relatives. 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 site visit was carried out by an inspector and specialist nurse advisor.

Prior to the inspection we used information the provider sent us in the Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with two people who used the service and 13 relatives. During our visit to the office we spoke with the registered manager; the operations manager, the paediatric clinical lead; the human resources administrator; the training coordinator; a registered nurse and a health care assistant. .

We reviewed various records of care including six care plans. We also examined medicines documents namely medication administration records (MAR) charts. We read documents including audits, records related to the employment of staff and the operation of the service.

Good

Is the service safe?

Our findings

People and their relatives told us they believed they were provided with a safe service. Comments included "They keep my husband very safe and take good care of him. There are always two of them if he needs hoisting", "I never worry about safety or risk. If there were any concerns they would ask me and I'm usually here so there are three of us", "They absolutely keep my son safe. The quality of the staff is good and they cope with everything."

Staff were trained in the administration of medicines. Medicine training for staff took place both face to face and using E-learning. Staff competences were assessed before they were able to administer medicines to people. The provider had a medicines policy and procedure. We found some information on three Medicine Administration Records (MAR) charts were not as complete as they should have been. For example one chart did not include the dosage of the medicine. Another did not give information about where medicine patches were placed on a person. There were no recordings to explain why the dosage appeared to be increased, when in fact the patch had fallen off and was replaced. A third related to one missed signature for the administration of a cream. Following discussions with staff we were satisfied that no one had come to harm. The clinical lead and the registered manager told us they would ensure recordings of medicines were enhanced.

We recommend the service improve their medicines audits to ensure consistently safe practice.

People and their relatives comments about medicines included "They [staff] text me to let me know he's taken it (medicines) and maintain a spread sheet with details of what has been taken and when", "Medication is always carefully documented and his tablets counted out", "Medication is well managed."

Staff received training and understood how to identify indicators of abuse. They were aware of how to report concerns. The service had a safeguarding policy in place. The provider also had the multi-agency agreement protocol for each local authority their service covered. This meant they understood their responsibility for the locality for each person they supported. One staff member told us if they witnessed anything untoward they would have no hesitation in reporting to the manager and the team leader.

People's safety and well-being had been considered by the service and steps had been taken to ensure that any risk of harm had been assessed. Risk assessments were in place for the use of bed rails and for moving and handling. Risk assessments had been carried out along with best interest decisions in collaboration with the Multi-Disciplinary Teams. Due to the complex needs of individuals it was essential that risks were identified and that staff were trained accordingly. We saw this was taking place and reviewed regularly.

Environmental risk assessments were in place alongside risk assessments related to the care provided for people. For example, fire risk assessments had been completed and the environment of people's homes to ensure safe working practices could take place.

Care plans provided guidance on how to reduce risk. This included guidance from health professionals and

specialist advisors where this was relevant. For example, risks to people's skin integrity were identified and assessed. Suitable pressure relieving equipment was identified and used to reduce risk. For example a pressure relieving cushion.

Prior to people receiving a service, their needs were assessed. This was to ensure their needs could be met. This enabled the service to plan the resources the person needed to keep them safe. Following the assessment the staffing levels required were decided. Staff we spoke with told us they felt there were enough staff to meet people's needs. Agency staff were used when there was a shortage of staff. Comments from people and their relatives were not positive about the use of agency staff. They included "Agency staff are a waste of time", "Some carers (staff) are regular and know my children but we often get agency staff who can't do things. I'm looking to try and get a regular team together of five (currently there were a regular team of four staff) I think Amegreen are working on this." One person told us "The night shift are mainly agency staff but are OK".

We spoke with the registered manager. They told us and documents confirmed that where there had been complaints raised about agency staff these had been dealt with. Records also highlighted the use of agency staff had been minimal over recent weeks. Recruitment was on-going to find suitably skilled and experienced staff to meet the complex needs of people using the service. Plans were also in place to establish a rapid response team who could carry out care at short notice. This would ensure the use of agency staff would be kept to a minimum.

Staff received mandatory training in infection control to ensure people and themselves were protected against the risk of illness. Staff were able to discuss with us the measures they put in place to protect against the risk of infection. The provider had an infection control policy in place to inform staff of the correct procedures to use.

Where accidents or incidents had occurred, these were recorded by staff. In all cases the incidents were investigated by the senior staff. This was to establish if there were trends and to prevent reoccurrences. We found there were no identifiable trends.

Recruitment systems were in place to ensure people were protected as far as possible from unsuitable staff. Checks included Disclosure and Barring Service (DBS) checks, written references, health checks, and proof of identity and of address. This process reduced the risk of improper staff being employed by the service.

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 applies only to people over the age of 16. Applications to deprive people of their liberty in domiciliary care services must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's mental capacity had been assessed for some decisions. Where people were found to be unable to make decisions for themselves a best interest process had been followed. This was in line with the MCA code of practice.

Records showed one child had their freedom of movement limited through the use of restraint. This was to protect them from harm. The decision to carry out care in this way had been discussed and approved by the funding authority and the parents. This ensured the child was safe and the risk of injury had been minimised.

New staff joining Amegreen attended induction training. This included training deemed mandatory by the provider such as safeguarding children and adults; moving and handling; administration of medicines; equality and diversity and infection control amongst others. Staff who were required to work with people who had complex health needs were provided with extra training in order to meet those needs. For example non-invasive ventilation (delivering oxygen by use of a face mask) or gastronomy feeding. (A gastrostomy is a feeding tube that is inserted directly into the stomach). Each staff member needed to have the skills and knowledge to be able to support the person they were working with.

We received mixed feedback from people's relatives about the quality of the skill set staff had in relation to the care provided. Comments included "I think they get basic training but are then sent out, it can be hard if the condition (person's health condition) is unique", "They're well trained in equipment use. Medication is well managed", "They need a lot more training and awareness. There's no evidence of them being checked. They don't show any initiative and I spend a lot of time showing them how to do things", "Previous Care Manager would come to the house and train the carers but not the current one. The new one said she would renew some of their training but I'm not sure that happened."

We spoke with the registered manager about this. They told us they were surprised by some of the reactions of relatives. Part of the quality assurance process involved relatives feeding back about the competency of staff. The majority of comments had been positive. The provider had purchased equipment to enable staff

to carry out practical training to ensure they were competent. They told us they would be following up on any concerns raised. Competency assessments had been completed and records confirmed this.

People were supported with their hydration and nutritional needs. Amegreen used a number of standardised evidence-based tools to assess people's needs, such as the Malnutrition Universal Screening Tool (MUST). This is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also used the Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) This provides a simple way of determining whether a child is at risk of malnutrition and also provides guidance to help develop a care plan according to the child's overall risk of malnutrition.

One relative told us the food had to be a certain consistency and pureed, they commented that 'They (staff) do this well'. Another commented "One of the Amegreen team led us towards a blended food regime which is a new thing worldwide and means he can have proper rather than synthetic food." (Blended food regime is the use of blended food being delivered via a tube to the stomach rather than a prescribed formula.) This ensured people received a diet appropriate to their needs.

Weights were looked at in all instances and were monitored on a monthly basis and where necessary on a weekly basis, MUST assessments ranged from medium risk to very high risk and where required there was involvement of GP and dietetic professionals. Professional involvement for GP or Speech and language therapy was documented in the multidisciplinary team notes located within the care files. Care records also demonstrated people received input from health and social care professionals including; opticians; audiologists; mental health teams; occupational therapists and palliative care nurses. This helped people to remain as healthy and comfortable as possible.

Good

Is the service caring?

Our findings

Comments from people and their relatives about the staff included; "They're brilliant. Carers often forget the hours and if he's having a bad day or when he's cold, provide extra heating or food and wait until I get home and report it", "They really care and it's very rare that we find someone who isn't bothered. They get my son Christmas and birthday presents and they look after us as a family too." One relative told us one staff member had made a lot of difference because they were proactive. They told us the staff member was concerned about ensuring that the person received good care and that problems were dealt with promptly. For example when there was a problem with their feeding system they ensured a doctor was called immediately. They told us 'He [named staff member] goes the extra mile'.

People's relatives told us about their involvement in the care provided and their relationship with Amegreen staff. Comments included '[Named person] interviews all the carers (staff) and has to feel happy with them. They really get on and are kind and caring", "They (Amegreen staff) have constant liaison with me and regular meetings", "I have a strong personal relationship with them, even the newer one (staff). One will stay after her shift if needed and in an emergency will come and get me from work".

There are nine characteristics protected under the Equality Act 2010. These are: Age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation. In the Provider Information Return (PIR) the registered manager described how they supported people with protected characteristics. " Clients are supported in following their choices be they religious, cultural or lifestyle." Examples were given of how staff respected people's homes and religious and cultural preferences. Support was given to people with disabilities to ensure they participated in a lifestyle that was meaningful and enjoyable to them. Staff received training in equality and diversity and how to support people with diverse needs. This supported staff to treat people as equals and ensure their care was appropriate to them as individuals.

The service was striving to ensure people had access to the information they needed in a way they could understand it and were complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place by the NHS from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Communication was an important aspect of the care being provided.

Some of the children using the service used Makaton. This is the use of signs and symbols to help people communicate. The service had two staff who had been trained to use this form of communication. It was planned for them to train other staff to enhance their communication skills. People who required it had communication passports in their care profiles and laminated and attached to their wheelchairs. Some people had access to electronic means of communication. Staff had been trained in how to use the equipment. This enabled more effective interaction..

People were assisted to remain as independent as possible. For example, making choices where possible. Staff understood the importance of giving people choices and allowing them to remain as independent as

possible. One person's daily records noted the staff had written the days they would be attending to support them in the following week. This was to assist them with their memory which was deteriorating and led to confusion. Staff knew and were able to give us examples of how they protected people's privacy and dignity.

Good

Is the service responsive?

Our findings

People's care plans were person-centred and reflected their cultural, social and health needs. Records showed and people confirmed their involvement in the provision of care. Comments included "They keep the care plan up to date and always ask for my input, and my husband's". People's involvement was evidence within the care files. This confirmed the information in the provider's PIR which stated "Clients have full control over their care profiles. They countersign the information where possible but also the addition of bespoke documents such as daily routines, photos of positioning, likes and dislikes and long term goals."

People were supported to participate in their chosen lifestyle. For example one person's relative told us "The two carers who really know him have more fun with him than I do! I often come back to find them laughing. They read the newspaper to him and when I'm away, do unexpected things like take him to the cinema." Other comments included "They support us when we do things as a family, days out and walks, and they play games with the children", "They help me with getting to work and shopping and make sure I have help with picking up the children", "My daughter loves having her hair done, going on her bike, reading and dancing. They (staff) get involved in all of this'

There had been a number of concerns and comments raised with us about the difficulties in recruiting the right staff. This was partly due to the specialised and often complex needs of the people using the service.

Staff needed to be trained and competent before they were able to care for people. In the event that they were not able to work it sometimes proved difficult to provide additional staff with the level of skills and knowledge necessary. We spoke with the registered manager about this. They told us they were aware of the concerns and had taken action to improve the situation. This took the form of employing new staff including care and nursing staff and by introducing the role of team leaders and care managers. It was the role of the team leaders to focus on managing the teams of staff attending to people's needs. This information was shared with the staff coordinator, whose role it was to design the staff roster.

The registered manager was trialling a new electronic system using a telephone application so that they could monitor when the staff roster was sent out to staff and people. What time staff visits took place and their duration. This was being used for two people, and teething problems were being ironed out before it was to be rolled out across the service.

The provider had a complaints policy and procedure. Staff were aware of how to access the information if needed, to deal with a complaint. We noted there were a number of complaints made to us when we gained feedback from people's relatives about the service. This included areas such as the recruitment of staff with the correct skills to carry out the care needed, rosters and the training for staff. We found the concerns mentioned to us had been raised with the registered manager. Documentation highlighted the action that had been taken or was taking place to address the concerns. Issues with staff conduct had also been dealt with appropriately.

People commented on the response from the service in relation to their complaints. These included "The Care Manager has now offered a different kind of care package which means that carers can come to the hospital with my daughter and give me a break", "There are a few timekeeping issues and problems with sickness absence, they don't have enough cover sometimes. One carer missed three shifts in a row. I raised it with [registered manager] who dealt with it and it didn't happen again and we got different carers involved." One relative told us "We kept running out (of medicines) and carers weren't anticipating my wife's needs. We had to keep telling them to do things". Since this has been raised with Amegreen they now have a key worker who is 'very diligent' and anticipates needs and ensures that all protocols including cleaning and updates to the care plan have taken place. They told us the key worker communicates with them if there are any issues. This demonstrated the provider used the complaints made to strive towards an improved service for people.

Some people had advanced care plans in place. These were completed with the involvement of family, and other important relevant people. The PIR stated "End of life care plans are essential in supporting our clients nearing the end of their life. We currently have the privilege of supporting a person with [named disease] whose end of life choices are very clear. A small team of dedicated staff support him and his family through his journey and care is adjusted on a daily basis." We reviewed the care plan of a person who had recently died. District Nursing service and palliative care teams worked alongside Amegreen staff to provide appropriate and supportive care.

Good

Is the service well-led?

Our findings

People and their relatives gave mixed feedback about whether they felt the service was well managed. Comments included, "It's not very well managed. I think the style is too reactive rather than planning ahead to address the overall needs", "[Named registered manager] always responds and I think manages Amegreen well", "It seems a lovely company but middle management aren't so good. I've sent a lot of emails to the care manager but get a very minimal response", "I have no complaints about the organisation and think it's well managed".

We spoke with the registered manager who told us they were working to ensure people were satisfied with the service they received. We read how action had been taken to improve the areas people had complained about. During our inspection we met the new senior staff who were settling into their roles. One was a new operations manager. Part of their role would be to meet people and their relatives and to discuss the care and any issues they had.

The service had also employed a new business development manager, a clinical lead, and a staff coordinator along with the introduction of team leaders and care managers. Whilst the service had grown over the previous twelve months, the registered manager wanted to ensure that the focus remained on the quality of the service. They envisaged the introduction of the new personnel would go some way to ensuring this happened. The interim operations manager had only been in post a week prior to our inspection. Together the operations manager and the registered manager aimed to address the concerns being raised and documents evidenced this had already happened in some cases.

The quality assurance officer monitored all monthly audit returns, compliance visits, complaints and compliments, safeguarding cases, information governance and notifications. Monthly audits took place for infection control, health and safety, care documentation and medication. An external organisation completed a service audit annually. The service had a service improvement plan in place, this included areas of consideration, actions and named people and dates for completion.

A number of internal meetings were held in order to identify, plan and address concerns, issues and developments. These included workforce development plan meetings, clinical operations meetings and training meetings amongst others. This was to ensure separate areas of the service were working together on shared goals and to review progress.

People and staff were encouraged to give feedback on different aspects of the service through a customer/ staff satisfaction survey. These were carried out in six monthly intervals. Mostly positive responses had been received. The quality and compliance officer collated the information and an action plan with recommendations was drawn up and discussed at senior staff meetings. This was fed back to the staff. This helped to drive forward improvements in the service for people and staff.

The service's PIR stated "Amegreen's vision is to provide the highest quality of care where possible and to support and look after our staff." We felt the service was trying to achieve this and were mindful of their

responsibilities. Staff told us they were well supported by the registered manager and the senior staff.

One staff member told us when they started working for the service they were working with the registered manager without knowing it was the registered manager. They said "I have worked with my manager who is fantastic… I didn't know she was my manager at the time… she's great." Another staff member told us " The aim is to help those with complex needs in their home. On the other hand they also help us." They told us the best thing about working for the service was the support and training they received. Staff told us the management were accessible and encouraging.

Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.

The management were demonstrating good practice and compliance in relation to the requirements of the duty of candour through documentation and discussion. However they were not aware that this practice was in line with the duty of candour requirements.

We recommend that the service seek support and training, for all staff regarding Regulation 20. Duty of Candour of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

The registered manager was a founding member of the East of England Tracheostomy Working party which were about to produce new guidance and a DVD on caring for adults with a tracheostomy. They are also members of the Multidisciplinary Association of Spinal Cord Injury Professionals (MASCIP), and the United Kingdom Brain Injury Forum .The service were members and approved providers of care for the Spinal Injuries Association. They are approved providers for the east of England Trauma Services Directory. This enabled them to both learn and develop best practice in relation in these areas. They planned to revisit the Investors in people scheme in 2018.