Axe Valley Home Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 7 and 12 June 2017 and was unannounced.

Axe Valley Homecare is registered to provide personal care to people living in their own homes. At the time of our inspection the service was providing support to 52 people. The service was run from a location outside Dorchester.

The service had a registered manager. 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.

When we last inspected the service on 27 April 2016 we had concerns about how people's risks were managed and there were issues about communication and accurate recording of medicines. Quality assurance measures were not comprehensive and did not provide an overview of themes or trends. There were breaches in two regulations and we asked the provider to take action about these concerns. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the identified breaches and told us that they would be compliant with the regulations by July 2016. At this inspection we found that they were no longer in breach, but that there were still areas for improvement.

The service did not have capacity assessments in place for people in line with legislation and did not have systems in place to assess a person's capacity or make a decision in a person's best interest where this might be required. We have made a recommendation about completing assessments of people's capacity.

The service had taken steps to try to improve communication where staff did not speak English as their first language. However people reported that they struggled to communicate with some staff and this had therefore not been effectively managed. We have made a recommendation about staff language skills.

Staff received training in some topics but felt that they needed additional training opportunities in conditions people faced to ensure that they had the correct knowledge and skills to support them. This had been identified at the last inspection but no changes had been made.

People had risk assessments which identified the risks they faced and gave general information about how to manage these. The service was in process of reviewing people's care plans and ensuring that risk assessments were individualised.

People and their relatives told us they felt safe with the staff who provided their care and support. Staff were aware of their responsibilities in protecting people from harm and knew how to report any concerns about people's safety or wellbeing.

People were supported by staff who were recruited safely and were familiar to them. Staff received supervision using an online system and were able to request face to face time with a supervisor if needed.

Where people received support from staff to eat and drink sufficiently, we saw that staff offered choices and prepared foods in the way people liked.

People told us that staff who supported them were kind and helpful and we observed that staff supported people in the way they preferred and treated people with dignity and respect.

People told us that they received a rota each week letting them know what staff were due to visit at what times. Where changes were needed to visits, or where staff were running late, people told us that the office generally made contact to let them know.

Peoples care plans included details about what people liked and how they wanted to be supported.

People told us that they were involved in reviews about their care and we saw that reviews were completed annually, or more frequently if people's needs changed.

Feedback was gathered from people through surveys and used to identify actions to improve the service. People told us that they would be confident to complain if they needed to and we saw that complaints were recorded and responded to appropriately.

Staff and people told us that the office was easy to contact and responsive. Team meetings were in place and regular newsletters and the PASS system were used to communicate effectively with staff.

Quality assurance measures were regular and used to monitor and identify areas for 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.

Risk assessments were in place and were in the process of being individualised.

People were supported by staff who understood their responsibilities in protecting people from harm.

People received support from staff who had been recruited safely with appropriate pre-employment checks.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had consented to support but where people lacked capacity there were no assessments or best interest's decisions in place.

Staff were knowledgeable about the people they were supporting But required further training opportunities in conditions people faced.

Supervision processes were in place to monitor staff.

People were supported to access healthcare professionals promptly when needed.

Is the service caring?

Good

The service was caring.

People had a good rapport with staff and we observed that people were relaxed in the company of staff.

Staff knew how people liked to be supported and offered them appropriate choices.

People had their privacy and dignity respected.

People were encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Care plans reflected people's needs and how they wished to be supported.

People were involved in reviews about their care and asked to feedback their views about the service.

People were aware about how to complain and where complaints had been received, these had been responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led

Feedback about training from internal surveys and the last inspection had not been addressed to ensure that staff had the correct knowledge and skills to support people.

Quality assurance measures were regular but did not consistently identify areas for improvement.

Staff and people told us that the office was available and responsive.

Axe Valley Home Care Ltd

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.

The inspection was announced and took place on 7 and 12 June 2017. Phone calls were completed on 13 June 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service to people in their own homes and we needed to be sure that someone would be at the office and able to assist us to arrange home visits.

The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including injuries to people receiving care and safeguarding concerns. We reviewed the notifications that the service had sent to us and contacted the local quality assurance team to obtain their views about the service. The provider had completed a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the provider does well and what improvements they plan to make.

We spoke with three people in their homes. We also telephoned ten people, four relatives and a health professional to obtain their views about the service. We spoke with six members of staff, the nominated individual, and the director of the service. We looked at a range of records during the inspection. These included seven care records and four staff files. We also looked at information relating to the management of the service including quality assurance audits, policies and staff training.

Good

Is the service safe?

Our findings

When we last inspected the service in April 2016, we found a breach in regulation around management of risks and accurate recording of medicines. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the identified breaches and told us that they would be compliant with the regulations by July 2016. At this inspection we found that they were no longer in breach and improvements had been made.

Staff were aware about the risks that people faced and their role in managing these, but records did not always support staff with this, for example one person had limited sight and staff were able to explain how they made sure that items weren't moved and that they explained to the person where they placed food and drinks and if they moved other items to manage this. The person's care plan explained about their sight loss and how they managed this in their home which assisted staff to know how to support the person. Another person had previously had a stroke. Their care plan explained what a stroke was and possible side effects but did not give any detail about how this had affected the person to give staff guidance on how to support them. This meant that staff needed to get to know the person to understand how their condition affected them because their records did not provide this detail. The recording system used by the service had been recently changed to an online system and the director explained that as people's care needs were reviewed, more individual details about people's risks and how to manage these were being added. We looked at some reviewed care plans and saw evidence that this was the case. This meant that the service had identified this area for improvement and were in the process of implementing changes to ensure that records reflected individual risks

The service had recently moved to an electronic system to records and monitor the provision of services for people. This system was called PASS. Where staff needed to provide particular support to manage the risk's people faced, this was clearly included in people's care plans as tasks for staff to complete and what outcome this would achieve. For example, one person was at risk of not eating or drinking without support from staff. The PASS system identified that the outcome was to ensure the person had adequate nutrition and hydration and staff recorded tasks to show what the person had chosen to have at each visit. If the person had not eaten or drunk anything, the PASS system highlighted this as an alert and specific staff in the office monitored these. This meant that there were systems in place to ensure that people's risks were safely managed.

People told us that they felt safe with the support they received from Axe Valley Homecare. One person said "yes I feel safe……I'm not worried about anything". We saw that staff supported someone to remember to wear their pendant alarm to ensure that if they fell when staff were not present, they would be able to raise an alert quickly. A staff member explained how they used a piece of equipment to support a person to move safely.

Staff understood about the possible signs of abuse and how to report any concerns. One staff member explained that they would be aware of "bruising, unhappiness , financial abuse, or other issues". They said that they would be confident to report any concerns they had. Another member of staff explained that they

would look for more subtle changes in behaviour such as a person flinching when they were providing support and told us how they would report concerns.

There were enough staff to support people and staff did not feel pressured to pick up extra work. People and relatives told us that the staff who provided support were generally familiar to them. One said "I generally have the same people which I like….they are a good group, they know me well". A relative said that they "normally send the same member of staff and they have a 30 minute window to arrive". Another relative explained that their loved one had "Got to know the regular staff".

Checks were undertaken on staff suitability before they began working at the service. These included references, identification, employment history and criminal records checks with the Disclosure and Barring Service (DBS). The DBS checks people's criminal record history and their suitability to work with vulnerable people. Any gaps in applicant's employment histories were checked as part of the recruitment process. The nominated individual explained that they had recruitment incentives in place for staff who recommended someone to work for the service, they also used various online resources to advertise and told us that retention of staff was generally good.

Accidents and injuries were recorded and monitored by the management team. Records included dates of when incidents had occurred and information about what happened and what actions were taken. For example, one staff member had sustained an injury whilst working. They were given advice from management and sought appropriate medical treatment.

People received their medicines as prescribed. The service were also using the PASS electronic system for recording and monitoring administration of medicines online. This meant that if any medicines were not given as prescribed, an alert would be raised on the system and the dedicated office staff monitoring these would then investigate why the medicine was not recorded as given. Where people needed assistance with applying topical creams, there were instructions for staff about where these needed to be applied. We observed a staff member assisting a person to take their prescribed inhaler by using an additional system in line with national guidance to make sure this was given safely. We looked at the MAR (Medicine Administration Record) for five people and saw that these had been recorded accurately. Where people required prescribed medicines on a short term basis, the director explained that they had requested that staff advise the office so that any new medicines could be entered onto the PASS system. Although this system was reliant on staff updating the office, it demonstrated that the service had considered how to ensure that medicines were administered as prescribed and were accurately recorded.

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 whether the service was working within the principles of the MCA.

People had consent forms in place in relation to the support they received. However where it was not clear whether people had capacity to make decisions about their care and treatment, there were no assessments in place. This meant that some people had support in place without consideration about their capacity or whether provision was in their best interests. For example, one person's medicines had been hidden away so that they did not know where they were. Staff and the director told us that this was because the person was worried about taking too many and anxious about this. The person did not know where their medicines were kept and there had been no assessment to determine whether the person had the capacity to consent to this or whether the decision to hide the medicines had been made in the best interests of the person. A staff member told us that there were other people in receipt of support whom they felt lacked capacity to make decisions, but again there was no paperwork in place to indicate that capacity had been assessed and where necessary, decisions made in people's best interests. This was an area for improvement.

We recommend that the service seek appropriate advice and guidance about ensuring that assessments are undertaken in line with the Mental Capacity Act 2005.

Staff received an induction and undertook the Care Certificate as part of this. The Care Certificate is a national induction for people working in health and social care who did not already have relevant training. Staff also completed shadowing with other staff before they worked alone which they told us was helpful.

Staff had training in four areas the service considered essential. These were moving and assisting people, medicines, safeguarding and mental capacity. Staff told us that they felt that additional training was required to improve their knowledge and skills about how to support people. For example, one staff member told us that they had not received any training or updates in the past year and had not received updates in how to move and assist people or safeguarding. This was not in line with the service policy on refresher training which stated that training in these two areas was required annually. The training matrix for the service indicated that these were planned to be updated in July 2017. Another staff member told us they had not received any training since their induction which had taken place over a year ago. They said that they had watched a video and been shown some equipment, but had not received any training since this. They told us that they picked up information about how to move and assist people safely from other staff that they worked with.

Two staff members told us that they had visited a person who used a type of continence aid in which they had not had any previous training or experience. There was a relative who guided them about how to use this, but this training was not provided by the service. The service had offered catheter training during a staff

meeting in September 2016 but had not offered training in this continence aid for staff. Another staff member told us that they had visited a person who had suffered a stroke. The staff member had not had training in this and said "(name) was able to tell me how it affected them. I don't know much about strokes". The service had not taken action to ensure that staff were provided with training which was relevant for the people they supported. The director advised that training was a priority for the coming year and that further opportunities for learning were being considered. They also advised that some staff were undertaking national qualifications in health and social care.

Staff told us that they received training about MCA, safeguarding, moving and assisting and medicines as part of their induction and we saw that staff had refreshers in these areas scheduled in for July 2017. One staff member when asked about how to improve the service said "Improve training so we can be more confident in supporting people". Another staff member told us that "More practical hands on training and refreshers would be useful". A member of staff told us that they had seen the paperwork for completing capacity assessments but was not confident to undertake these until they had received training in this area.

Staff had planned supervision every six months and one of these was arranged as an annual appraisal. Supervisions were sent out to staff online and completed and returned electronically. Staff did not received face to face supervision but were able to express a wish for this on the electronic form. One staff member had not received supervision or an appraisal in over a year. Another told us that they had completed their appraisal online but not received any follow up from this, although they had requested a face to face meeting. The nominated individual explained that they had a dedicated staff member who provided supervision for staff and arranged these face to face where these were requested. This staff member worked part time and provided supervision for all staff at the Dorchester branch and also the Seaton branch of Axe Valley. We saw that supervisions included information about what support staff needed and whether they felt their workloads were manageable. They also included details about how staff provide support to people. For example, one supervision required staff to consider record keeping and why this was important.

Staff communicated well with people and understood that people had different communication needs. For example, one person had limited sight, we observed that staff introduced themselves with a nickname the person understood, and stayed close to them when they spoke so that the person could see them. Where people had limited hearing or other communication needs, these were reflected in their care plans so that staff were aware of people's individual methods of communicating.

People were supported to have enough to eat and drink by staff who understood what support they required. We observed that staff asked a person what they wanted for breakfast and prepared their choice in the way they liked. Another person needed a softer diet and staff prepared their breakfast and reminded them to let it soften before they ate it. They were aware of what foods the person was able to eat safely and knew their preferences and dislikes. People's care plans also outlined individual needs, for example, one person's information indicated that they struggled with cutlery and preferred to have finger foods to manage independently.

People had access to healthcare services when required. One person had regular visits from District Nurses and staff were able to explain how they monitored the person between these visits and what concerns they would be aware of and raise back to the surgery if needed. Staff told us that they arranged visits from health professionals where people needed this and said that the office were effective in arranging these when they were requested.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and caring in their approach. One person told us "They're wonderful, what they do for you (staff)…..anything I want…it's done". Another said "they are lovely, they will do anything for me". Another told us "they go that extra mile and always check if there is anything else I need". We observed that staff were tactile and gentle in their approach. Staff spoke with warmth and affection about people and knew them well. Conversations with people were relaxed and informal with appropriate humour and rapport.

People told us that staff knew what their preferences were and how they liked to be supported. One person said "they know exactly what I like and what I want". A staff member told us that one person liked a tactile approach and we observed that the person responded warmly and positively to this when staff visited them. Another staff member told us about a person who they were concerned was low in mood. They explained that they were soft in their approach and in how they spoke so that the person felt supported and reassured.

Staff treated people with dignity and respect. We observed that staff entered people's homes in the way they preferred and were respectful in the way they spoke with people and offered support. A relative told us that staff were "respectful when they come into our home". A person explained that staff were "Very respectful… close doors and curtains…call me by name". Another said "They are very polite and will knock if I am in the bedroom before coming in".

People were offered choices about how they received their support and staff understood how to offer choices in ways which were meaningful for people. For example, a staff member explained how they showed a person's choices visually so that they were able to decide what they wanted. One person told us "They will always ask what I would like". A staff member explained how they sought consent from a person to provide support and respected if the person declined. They monitored how often the person declined and the PASS system alerted the office if there was a risk that the person's skin integrity might be affected.

People were supported to retain their independence. Staff understood their role in supporting people to retain their abilities and encouraged people to do what they could for themselves. For example, one person told us "I can do lots for myself, it's important to do what you can…keeps your mind sharp". We observed staff giving a person verbal prompts to assist them rather than physically assisting the person. This enabled the person to manage the task with minimal assistance.

Good

Is the service responsive?

Our findings

People had care plans which mostly reflected their individual needs and how they wished to be supported. They included a summary section which gave some information about peoples' histories and what was important to them. For example, one summary included previous hobbies and interests and information about those that were important to the person . This meant that staff were able to have conversations about areas which were meaningful to people. Where summary information was not yet updated onto the PASS system, there was a plan in place for these to be added as part of people's reviews.

People and those important to them were involved in reviews about their support. One person told us "I've had a review…..they checked how everything was going". A relative told us that before the support started for their loved one "We were involved… (staff) came and asked us what we wanted." The care plan was then developed for the support they would receive. Another relative told us that they had an annual review and staff went through the care plan with their loved one. We saw evidence of reviews taking place and that changes were updated on the system to ensure that information for staff was available and responsive to people's changing needs. Staff had received guidance around how to record any changes to the support people received and further work was planned to consider how changes to people's lives could also be reflected in a timely way. For example, one person had lost a pet and could become upset if this was discussed. This was not reflected in their care plan. Office staff made this change as soon as we raised it and the director explained that they would continue to work with staff to ensure that they were responsive to the changes in people's lives.

People received regular rotas which told them what staff would be supporting them and they told us that if there were changes to the rotas, the service rang to let them know. We saw evidence of rotas in people homes and one relative said "Staff have a 30 minute window to arrive and we have the same person". They were aware to call if staff were outside this time frame. Another person said "They ring and inform me if there are any changes".

People's preferences were listened and responded to by the service. The office were able to record whether people preferred female or male staff and if a person did not want male staff, the system would not allow male staff to be booked. There was an option to accept in an emergency and in these situations, staff rung people to check they were happy to accept before sending staff. A relative told us that they had asked not to have a certain member of staff and the service had responded to this and they had not been sent again. The system also allowed staff to record whether people had particular staff members they preferred and the care-coordinator would consider this when booking the staff for visits.

The new PASS system meant that people did not have paper records about the support they received in their homes. All records were kept on the system and could be viewed by staff using individual log ins. Some people still had paper recording books in their homes and the office advised that this was offered to people and their relatives if they still wished to have a paper record of support. One relative explained that they had needed to request this several times, but that it was now in place and meant that they could see what support their loved one had received. There were systems in place for relatives to remotely log in to the

PASS system and see what support their loved one had received if they chose to do so. Relatives told us that they were updated promptly by the service if their loved ones were unwell or if there were any changes. For example, one staff member explained that they had left a message for a relative of a person to advise them about a change in their need.

People and relatives told us that they would be confident to complain if they needed to. We saw that people had copies of the complaints policy in their homes and a relative told us "If I had any concerns at all I would be confident to raise them". Another said "I can raise concerns…they are quite good and respond. " They gave an example when they had raised an issue with the office. They told us that this had been listened to and resolved quickly. We saw that complaints were recorded and details included the nature of the complaint, what actions were taken and any learning from these.

Feedback was gathered through an annual survey and regular satisfaction calls to people. The calls included checking whether people could identify any areas for improvements in their support and monitoring whether staff stayed the full duration of their visit and were dressed in appropriate uniform. Where these calls highlighted any changes, these were fed back into people's care plans.

Requires Improvement

Is the service well-led?

Our findings

When we last inspected the service in April 2016, we found a breach in regulation around quality assurance measures and lack of action concerning communication. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the identified breaches and told us that they would be compliant with the regulations by July 2016. At this inspection we found that improvements had been made in quality assurance but that this was still an area for improvement.

At our last inspection we had highlighted that training was an area which required improvement and this was still an area for improvement at this inspection. At this inspection we were told by staff that no changes had been made to training and the majority felt that they needed additional opportunities. The results of the service user satisfaction survey in 2016 identified that eight people felt that staff needed additional training opportunities to meet their expectations. Actions were planned to address this, including investigating options for training in dementia and learning disabilities. At the time of inspection, the provider had not acted on the feedback received around training in the last inspection or the service user satisfaction survey and had therefore not taken steps to ensure that staff had the required skills and knowledge to support people appropriately. This was an area for improvement.

Communication between people and staff was an area which had been identified in the last inspection because it had not been effectively managed. We were consistently told that staff were caring, but that communication with some staff continued to be a barrier if staff had limited language skills. Information from the service user satisfaction survey in 2016 identified that eight people had expressed a preference for more staff who were fluent English speakers. Six people we spoke with also identified that language was a barrier to communicating with staff. One person suggested that management could, "Help the carers with improved language skills" as a way of improving the service they received. The director explained that they were investigating local and online options for language courses but these were not in place at the time of inspection. The service did not have any systems in place to determine whether staff recruited had sufficient language skills before they started in their role. Although the service had taken some action following the last inspection to consider this as part of future recruitment, communication was still identified as an issue both during our inspection and as part of the internal survey completed by the service. The service had not acted upon feedback received for the purpose of improving the service people received.

We recommend that the service seek appropriate options to support staff to improve language skills.

The service completed regular phone monitoring with people and completed observational competency checks with staff to assess and improve the quality of the service provided. Calls to people did not specifically consider communication skills of staff and had not identified that any improvements to language skills were required. Observational competency checks of staff did include communication skills but had not identified that any staff required further development of their language skills. This demonstrated that some quality assurance measures were not effective in identifying areas for improvement.

The introduction of the PASS system had improved the accuracy of medicines administration. If medicines were not administered or not recorded, the system alerted dedicated staff who followed these up with people and staff. This meant that any errors were identified and acted upon effectively and audits showed that accuracy had improved and that people were receiving their medicines as prescribed..

Staff and people told us that they were able to get hold of someone in the office when they needed to. There was an on call system which managed calls from both the Axe Valley Dorchester service, and also the sister office in Devon. If people were unable to get through, messages were returned and feedback was positive about actions taken where needed. For example, where a person requested not to have a particular member of staff, this had been respected.

The service held team meetings which staff were invited to attend. Some staff told us that this was difficult because they lived and worked some distance from the Dorchester office. One staff member told us that they did not receive information about what was discussed in team meetings if they were unable to attend which made communication difficult. However other staff told us that they were kept updated through newsletters sent out by the service. These included information about various topics including consideration about security at peoples' homes and updates about how to record accurately on the new PASS system. The director explained that monitoring the data on the PASS system had highlighted areas for improvement in how staff recorded information about the people they visited. They had developed a policy to provide additional guidance in response to this and circulated this to staff. This demonstrated effective management because the service had taken steps to support staff and improve the accuracy of recording.

The service used a recognition scheme to motivate and recognise high quality care. Information was gathered from compliments received, observations and satisfaction calls and surveys.

The service had development plans which included further implementation of PASS which would include a system for staff to be able to check themselves into and out of people's home to accurately monitor visit times and any missed or late calls. The website for the service was not operating when we inspected. The director explained that they were in the process of improving this and had an external company providing support.