Agincare Live In Care Services Limited

Agincare Live-in Care Services

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

Overall summary

This announced inspection took place on 11 and 12 November 2015 and we spoke with people using the service, relatives of people using the service, staff and professionals over the following week.

Agincare Live In Care Services provides care to people in their own homes. They provide live in care staff to support people with personal care needs throughout England and Wales. At the time of our inspection there were 173 people receiving personal care, although this number changes regularly.

At the time of our inspection the operations director had applied to become the registered manager but this process had not been completed. This meant that there was not a registered manager in post and, due to a number of staff changes, there had not been a registered manager in post since July 2013. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our inspections in July 2014 and February 2015 we had concerns about how people were cared for, how they were protected from abuse, how staff were supported, how medicines were administered, how risks were

Summary of findings

identified and managed and how quality was ensured. After our inspection in February 2015 we told the provider to take action about these concerns and they sent us a plan detailing that they would have addressed them all by the end of October 2015. They sent us updates of their progress during this time.

At this inspection we found that improvement had been made and there were no longer breaches of the regulations.

People, and relatives, told us they were happy with the care and support they received from the

service. Live in Staff spoke about the people they were supporting with kindness and respect. This was mirrored by the staff in the office who spoke about people and live in staff in the same manner.

People received support from staff with the right skills and knowledge. This support met their needs and reflected their preferences. Their opinions were sought and reflected in how they received care and how the risks they faced were managed. They were involved when their care needs were reviewed. Care was provided in line with the principles of the Mental Capacity Act 2005. This meant that people were supported to make as many decisions about their care as they could. When they were unable to make their own decisions these were made in a way that did not involve unnecessary restrictions and the opinions of people who knew them well and, if appropriate, relevant professionals were consulted.

People were protected from harm. They told us that they felt safe. Staff understood what their responsibilities were in relation to identifying and reporting suspected abuse.

The support people received was monitored to ensure that any quality issues were addressed.

People and their relatives were listened to and suggestions and if complaints were received these were acted upon appropriately.

Summary of findings

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 at a reduced risk of harm and abuse because staff knew how to recognise and report abuse.

People's risks were assessed appropriately and care plans provided guidance on supporting people in ways that minimised risks and promoted independence.

Staff were recruited safely and there were enough live in staff to ensure people were supported by someone with appropriate skills.

People received their medicine safely.

Is the service effective?

Good

People's care was delivered effectively. People were confident that the staff had the skills and knowledge they needed to meet their needs.

Live in staff worked in partnership with people, coordinators and health professionals to ensure people's health needs were met.

People were supported in line with the principles of the Mental Capacity Act 2005. Staff promoted people's ability to make decisions and acted in their best interests when necessary.

People were supported to eat and drink safely and to have choice and involvement in meal planning.

Is the service caring?

Good

The service was caring . People and their relatives spoke highly of the live in staff and the staff in the office. People were supported by staff who were well matched, enabling them to build positive relationships.

People were listened to and involved in making decisions about their day to day care.

People were treated with dignity and respect and their privacy was protected.

Is the service responsive?

Good

People received a responsive service. They had care plans which provided their live in staff with guidance on how to meet their needs and staff involved people in activities that reflected their preferences. When a change in their needs was identified people's care plans were updated.

People and their relatives were listened to about the care they received. They were able to contribute to their care plan and if they were not happy about something they were able to raise complaints and these were responded to appropriately.

Is the service well-led?

Good

The service was well led.

The management structure reflected the needs of the service, staff and people.

There were systems in place to check on and improve the quality of care people received.

Summary of findings

Staff understood their roles and felt able to seek support and guidance from their managers.

The operations director had applied to become the registered manager and this application was in progress.

Agincare Live-in Care Services

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 took place on the 11 and 12 November 2015 with calls taking place until the 19 November 2015. The inspection was announced because the service provides care in people's homes and we wanted to arrange contact details and home visits. The inspection team was made up of one inspector, a specialist advisor, three bank inspectors and an expert by experience. The specialist advisor had expertise in safeguarding, risk management within the community and the MCA 2005. The expert by experience had specific knowledge about the needs of older people and people with disabilities in a community care setting.

Before our inspection we reviewed information we held about the home. We did not have the Provider Information Return (PIR) available as the provider had not been asked to provide this information at the time of our inspection. (The PIR is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make.) We gathered this from other information we held about the service including notifications of incidents since the last inspection. (A notification is the form providers use to tell us about important events that affect the care of people using the service.) We considered the action plan that the provider had sent us after their previous inspection. During the inspection we gave the provider opportunities to tell us what they did well and what they planned to improve.

During our inspection we visited seven people in their homes, and spoke with a further 31 people who received care from the service in their homes by telephone. We spoke with four relatives and 27 members of live in care staff. We also spoke with ten staff in the office. This included staff with responsibility for coordinating people's care in the office (office coordinators) and those who had responsibility for supporting and supervising staff and reviewing people's care in their homes (Regional coordinators). This also included staff with responsibilities for staff training and support, recruitment and quality assurance. In addition we spoke with the deputy manager, care manager, operations director and the nominated individual.

We looked at 16 people's care records, and reviewed records relating to the running of the service such as staff records, accident and incident records, and quality monitoring checks.

We also spoke with a four social care professionals who had worked with the service.

Good

Is the service safe?

Our findings

At our inspections in July 2014 and February 2105 we had concerns about how the service kept people safe from harm and abuse and how medicines were administered. There were breaches of regulations. We required the provider to make improvements. They told us they would make these improvements by October 2015 and kept us informed of their progress towards this. At this inspection we found improvements in how people were kept safe from harm and abuse and how medicines were administered.

People received their medicines as they were prescribed. They told us they were happy with the support they received around medicines. On person described this support by saying: "Spot on. I always get the right ones." Another person told us: "I've got what I need; they give me it at the right time." Staff understood the medicines they were supporting people to take and knew what to do if they were concerned about side effects. One member of live in staff told us: "(Person) takes a number of medicines, I have a list and I know what they are for."

Whilst most records relating to medicines were complete we found that one person did not have a record of creams that their live in staff had been applying for them. This had been picked up the previous day by a regional coordinator and the live in staff told us they would be recording this. Another person was described as not needing help with their medicines but they were getting help due to short term memory loss. Recording how people are supported and the delivery of that support are important to ensure that people receive their medicines safely and that the quality of this support can be reviewed.

People were protected from the risks of receiving unsafe care as staff received appropriate information regarding people's individual risks. People and staff described how this information was held in care plans that were accessible in people's homes and through a handover with the member of live in staff who was leaving the person's home. This meant that people were supported by staff who understood the risks they faced. For example we visited a person who was a t risk when climbing the stairs in their home. The care plan described how live in staff should support them to do this and the live in care staff member was able to describe this process to us. Another person used Oxygen in their home and the live in care staff were able to describe the risks involved with this and what they did to reduce these risks. People told us that they felt safe. One person said: "I feel very safe indeed."

People's views were taken into account and healthcare professionals had been involved to ensure that risk assessments and the associated care plans were appropriate. One member of live in care staff described how the risks a person faced with their mobility were mitigated. "We use hoists and try and promote mobility where possible. A stair lift has been put in. We explain all equipment to new carers. We have an occupational therapist and they checked safety."

When new risks were identified the new staffing structure meant people received a quick response from regional coordinators who had met them previously. For example, during our inspection it emerged that a person did not want to use the lap belt when they used their wheel chair. A regional coordinator was able to update their care plan the next day in a manner that reflected the person's informed decisions and gave guidance to live in care staff.

People were at a reduced risk of experiencing harm and abuse because staff working in the office and in people's homes understood how to recognise and report abuse. Staff told us that they would contact their managers in the first instance and that there was always a senior member of staff 'on call' who was available for guidance. One live in staff member described how they had been concerned that a person may have been neglected and described how they reported this to the office. Another live in staff member told us: "I would report it to the office or the safeguarding team."

Allegations of potential abuse were responded to appropriately. We reviewed records related to safeguarding over a three month period ending in October 2015. Where it was appropriate to do so, the relevant safeguarding authority had been alerted and the Care Quality Commission had been informed. People and staff were made safe by the immediate responses of the management team and appropriate actions followed. Staff were suspended from work if this was appropriate and concerns were investigated. Where actions were needed these had happened. For example when training needs and spot checks were identified as necessary these had taken place or there were plans to ensure that these happened.

Good

Is the service safe?

There were enough suitably skilled live in care staff to ensure that people received the care they needed. Where people needed their live in care staff to have specific skills and knowledge such as how to support people with their catheter care or oxygen therapy safely they were matched with staff who had these skills. One person described the skills of their live in care staff saying they were: "very safe and competent". Planning to ensure appropriate staff were found for each person was evident during our inspection. It was discussed at the weekly team meeting and again at a meeting of the office coordinators and managers. Office coordinators explained that most people had regular live in staff and some now had regular cover for when the permanent live in staff took their breaks. They described finding appropriate staff as becoming more proactive rather than a reactive task. During our inspection most people's live in care staff cover for the holiday period had been planned and office coordinators were starting to arrange the live in staff who would take over following this period. They were also making sure that emergency cover was available for this time. This reflected the style of working that one office coordinator referred to as "smart working".

Staff were recruited safely. The records of live in staff had contained evidence that checks had been made to reduce the risks of employing people who were unsuitable for care work. The process of recruitment also included the successful completion of four day induction training. We saw that the dementia awareness session of this was detailed and person centred and led to a discussion involving the candidates. When candidates did not have care experience they were asked to work for a period of time dependent on their learning needs in one of the provider's care homes. This meant live in staff had practical experience of providing care before going into people's homes and the managers were able to assess their suitability more effectively.

Good

Is the service effective?

Our findings

At our inspections in July 2014 and February 2015 we had concerns about how staff were supported and how risks associated with eating and drinking were managed. There were breaches of regulations and we required the provider to make improvements. At this inspection we found that improvements had been and people now received safe support from staff who were appropriately trained.

People received care from supported staff that had the necessary knowledge and skills to meet their needs. People and relatives told us that the staff were good at their jobs. One relative said, "They all look after (relative) beautifully, all of them. I can't complain about the care." A person told us, "They know what they are doing….I am well looked after." Staff received an extended induction training before they started work, which included areas that had previously led to concerns raised by people such as their ability to cook. There was also an on-going programme of training for staff to keep this training current. Training was delivered by a variety of methods including online and classroom based sessions with the addition of practical competence based assessment for manual handling and medicine administration which was done whilst people were in placement. There was a system in place for ensuring staff were up to date with their refresher training and this was working effectively. The service had introduced the Care Certificate and new staff were being enrolled on this nationally recognised induction programme.

Staff told us they felt supported. We heard comments like: "Yes I do feel supported. They call and ask me how it is going." And "I have felt supported… we are supported." One member of staff told us: "I have regular visits from my regional coordinator." This reflected feedback from the majority of live in staff who had seen the regional coordinator and had their work observed. Another member of live in staff commented: "The same few people supervise me. I am well supported. Carers describe spot checks on the support they provided at varying frequency some every two to four weeks. This reflects the work and plans of the regional coordinators who were now aiming to visit each person on a six weekly to two monthly basis unless they required more frequent visits. Staff also felt they had back up in difficult situations. One member of live in staff told us: "All the time there is someone to speak to at the agency, I can call 24 hours."

Supervision and appraisals were also booked with regional coordinators and they had access to people's previous supervision records. This meant that ongoing issues such as training requests and practice concerns could be followed up effectively. One regional coordinator had started to provide live in staff with a folder to retain their own training and supervisory records.

In addition to their supervision sessions and spot checks, live in staff now had the option to talk after every placement. This provided an opportunity to explore training needs, share concerns and positive experiences and gave staff in the office more information about the challenges of the live in staff role. This was viewed as a positive by all staff. One member of live in staff had fed back the importance of this opportunity stating: "Talking

helps to relieve the burden."

Most staff were able to describe how the Mental Capacity Act 2005 provided a framework for the support they provided people. 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. One member of live in staff described how they would respond if someone refused aspects of their care: "I would try and convince them to the contrary but if they still say no I will respect their decision. I would tell the coordinator depending on what it was." Another talked about what would happen if people's ability to make decisions was changing: "I would look to see if changes and I would listen and look closely to help decide capacity." Staff were clear that some decisions would cause them to seek further advice; one live in staff described how if a person repeatedly refused medicines they would seek advice from the GP as well as talking with a coordinator. There was evidence that consent had been gathered appropriately in

Good

Is the service effective?

care records. Where people had been assessed as not having capacity to make decisions about their care these decisions had been made in line with the MCA Code of Practice.

Some of the people who received a service did not have the mental capacity to make decisions about their care and where they lived. The managers had reviewed these people and none of them met the criteria that would require the Court of Protection to authorise a deprivation of their liberty.

People were supported to eat and drink safely in line with their assessed needs and in ways that reflected their preferences. Where there were risks of choking staff understood these risks and were following guidance. If people received nutrition via 'medical feeding' tubes the live in staff had been trained to do this safely by an appropriate health professional. Records around food and drink were kept in the detail that the person needed to stay safe and well. People planned their meals and shopped for food with support where this was their choice. Staff had a good understanding of people's preferences and offered choice appropriately. One person told us: "They're good cooks. We discuss what to have. They are excellent." Another person told us: "They help prepare food; they make things I like and give me choice."

People told us that they were supported to access health care and to maintain their health. There were examples of people being supported to access health services for a range of physical and mental health needs. Live in staff were able to describe how they liaised with health professionals who had regular involvement with the person they were supporting, and how they sought advice when the person's health changed. One member of live in staff told us: "I liaise with the nurse who comes once a month." Another described how they had sort out better equipment to protect the person they were caring for from pressure ulcers . We saw records that evidenced discussions with GPs this about medicines changes and falls. One person was being supported to keep their hearing aid working.

Good

Is the service caring?

Our findings

Staff in the office and in people's homes spoke with care about the people they supported and their colleagues. A live in care staff member summarised this about the person they were supporting saying: "I want them to enjoy life." Staff knew people well and spoke with respect and care about likes, preferences and personality traits of people they provided care to. They told us this helped build positive relationships. One person told us: "It couldn't be better if they tried. They know my likes and dislikes."

People with regular live in care staff described positive caring relationships. We heard comments about live in staff such as: "It is hard to believe I am so well treated, it's like having them as one of the family.", "They are very gentle and listen.", "They are bright and have a good sense of humour… (Live in staff) is very kind to me." We also heard similar comments about the office staff. One person told us: "They are very pleasant to deal with. They have some good people there." One person described how this relationship had helped them, referring to a recent experience: "(Live in staff) was fantastic recently. I was at hospital late at night; they stayed with me and reassured me. I have a phobia of hospitals. I would have walked out. I can't thank them enough." They further explained that as an organisation: "Agincare (Live in Care Services) are reassuring and kind." And told us they believed this had led to an improvement in their health.

People who were able to direct their own support did so. They described how they discussed their care plans with the live in staff but that ultimately the decisions were theirs to make. One person told us: "I can always say what I want and feel in control." Another person told us: "they always ask me what I want." This was reflected in the ways live in staff described the support provided. One live in staff member referred to the person they were supporting affectionately as the "boss". Where people were not able to make all the decisions for themselves, live in staff described how they encouraged choice making along with other skills that supported the person's independence. Where individual choices could be deemed as unwise the live in staff respected these. The Staff considered if these risks were manageable and recorded the person's choice in their care plan.

People were supported in ways that protected their dignity. One person told us: "They always help me look my best, which is what I want." Live in staff were able to describe the ways they did this including protecting people's confidences, ensuring that their homes were kept the way they wanted, ensuring dignity was protected whilst personal care was carried out. Some live in care staff also described the importance of speaking up for the person to ensure they got the help they needed to live the life they wanted. Two members of live in staff had recently chased up services the person they were supporting needed.

The importance of good matching of staff with people and supervision in ensuring that people were able to develop positive relationships was described by relatives and people. One relative referred to how the live in staff with their relative were respectful saying: "they have been unobtrusive and deferential." Another relative had complimented the new member of live in staff saying: "They have a perfect personality match, and what an absolute diamond they are turning out to be." Compliments from the relatives of people who had died reflected a specific appreciation of the right live in staff providing quality care at the end of people's lives.

Good

Is the service responsive?

Our findings

At our last inspection in July 2014 we had concerns that people were at risk of not receiving appropriate care because their care needs was not reflected in their care plans. We were also concerned that complaints raised by people did not leave to improvements in care practice. There were breaches of regulations and we asked the asked the provider to take action to improve these aspects of the service. In February 2105 we remained concerned that people's care did not always meet their needs and that complaints where not addressed appropriately. We required the provider to make improvements and at our inspection in November 2015 we found these improvements had been made.

People's care was planned and delivered in a way that met their needs and preferences. People told us that they were involved in designing their care plans and that the care they got was right for them. One person said, "I have a good care plan. I go through it and have a say in it about how things go. They change it if I ask."

People's care plans contained information about the person, including their preferences, likes and dislikes and the level of support needed. They included personalised information relating to aspects of care such as communication, eating and drinking, mobility and specific health needs. They also covered social needs, one person's care plan reflected the person's needs for continuity of staff; this was reflected in the care they received. Staff told us that these care plans were useful and reflected care needs accurately. One member of live in staff said, "We have a care plan, it is useful and up to date." Live in staff told us that in addition to the care plan they had a handover period with the previous live in staff. The handover time varied dependent on whether the live in staff were new to the person and how complex the person's care needs were. We saw these varied from a couple of hours to more than a day. This meant that live in staff understood the care needs of the people they were supporting and were able to describe the support they provided to us. One person told us: "They are good, they support and care, (live in staff name) anticipates the things that you need." Another person told us that their live in staff was: "Always around when I need them." Relatives also commented positively on live in staff member's ability to meet their relative's needs within their own home.

People's care needs were reviewed appropriately. Live in staff reported changes in people's needs to their office coordinator who arranged for the regional coordinator to go out. During our inspection an office coordinator noted a change to a person's medicines during a weekly call with the member of live in staff. They sent this information to the person's regional coordinator who would be able to prioritise this based on their knowledge of the person. Office and regional coordinators told us that the restructuring of the service to provide an office coordinator and regional coordinator for each person receiving care and the live in staff working with them made them more responsive. They told us that they understood where the biggest risks existed for people and live in staff within the geographical area they covered and they were able to plan their time using this knowledge. A regional coordinator shared changes in their diary that evidenced how they responded to people's needs. These included visiting a person's home after a relative had highlighted some minor concerns about the suitability of the live in staff, visiting a person after a sudden change in their needs, and ensuring an appropriate handover took place when a live in staff member had to leave for unavoidable personal reasons.

We reviewed complaints received over the four months prior to our inspection. They had been handled in a timely manner and concluded appropriately. Investigation notes covered the issues raised in complaints and these were explored with the relevant people. Where training needs were identified these had been actioned. An audit had been undertaken of the complaints with actions identified and learning points for the senior member of staff with responsibility for responding to complaints. We discussed this with them and they told us they were also supported in the task by a manager. The system was effective and robust and led to actions that protected people and improved the quality of the service. We heard from people and relatives that informal concerns were usually dealt with effectively. Relatives and people described how feedback about carers had been taken on board by office coordinators.

Office coordinators and regional coordinators described how feedback from people, and relationships developed since the development of their geographical areas helped them match people with live in staff. People told us that they were mostly well matched with their live in staff. One person told us: "We're like old buddies. We get on like a house on fire."

Good

Is the service responsive?

Formal feedback had also been sought from people using the service and there was a schedule in place for gathering wider feedback. People had been asked to comment on aspects of their care, their live in worker and their experience of contact with the office. Most feedback received had been positive and this reflected comments made to the office coordinators during weekly calls.

We heard from people about how they were supported to access activities that they enjoyed or matter to them. One person told us that their live in staff: “Take me to the community centre when there are any functions to do with the church.” Another person had started an exercise program that involved going to the local swimming pool. We also heard of live in staff who were encouraging people to make links within their community. One live in staff member described how they had supported a person to make links with their local good neighbours group to give them more opportunities to make connections with other people.

Good

Is the service well-led?

Our findings

At our inspections in July 2014 and February 2015 we found that whilst there were systems to monitor the quality of the service and promote high quality care, these were not effective. There was a breach of regulation and we told the provider to make changes to ensure improvements in this area. At this inspection we found these improvements had been made.

Since our last inspection the staffing structure and operational systems had been reviewed and changed in response to the needs of the service and the people receiving care. The staffing structure now enabled the office and regional coordinators to develop relationships with people, their relatives and key stakeholders and each other. This meant that people received a more responsive and effective service. Systems that ensured staff were trained, supervised and offered support had been altered and a new support role created. This meant that the live in staff felt supported and had the skills they needed to meet the needs of people receiving care. These changes had been noted by some of the people receiving care and their families. One person told us: "Seem to have got a few more staff coming out more often, such as the coordinator to check things are ok. Before they came twice a year, but now it is every two months which is good." A relative told us: "There is more supervision now; they are improving their systems and correspondence." Where live in staff had noticed changes they also described them positively. One live in worker said: "it's improved a lot, connections between the office and us is better. It ensures the person... they get the best care."

There was an operations director in post who had applied to be the registered manager of the service. They worked closely with the care manager and deputy manager were now able to focus specifically on operational issues. This had enabled them to develop a good understanding of the service people experienced and the challenges facing the live in staff. This understanding was reflected in the understanding of all the staff in the office. Staff were able to describe the functions of their roles and understood where this fitted within the plan to develop and improve the service as a whole.

Plans put in place following our last inspection had been actioned and there were ongoing plans to further improve the service. This included further opportunities for office coordinators to visit people and their live in staff. This opportunity was valued by these staff who told us it helped them be more responsive in their role.

There were systems and structures in place to ensure that the quality of service people received was monitored and improved. Quality checks and reviews were undertaken by senior staff and these led to action being taken when necessary. We saw that complaints had been audited and medicines administration records were being checked during our inspection. The complaints audit had highlighted actions needed that had been undertaken. Accidents and incidents were reviewed and action taken to reduce risks. Record keeping was reviewed as an ongoing process and live in staff were given feedback on areas for development. Regular reporting within the line management structure also ensured that tasks such as support for live in staff were planned in a timely manner. These processes ensured that improvement actions were understood by all the staff working with people.

The team in the office were becoming more established and this consistency led to an improvement in quality. Staff were able to discuss learning informally with colleagues and team meetings and this led to improvements in the service people received. For example, learning from the holiday period of 2014/2015 was being used to plan the holiday period 2015/2016.

Communication with staff reflected the way the service was delivered. Staff meetings were held in the office, and important information was also shared by phone and email. The next newsletter for live in staff was also being developed to share information with the team as a whole. Professionals who worked in partnership with the service identified that recent communication via the office was effective and they received information in a prompt manner. One member of live in staff commented on this: "Recently things have really changed and information is really getting through." And another live in worker told us: "They are now in regular contact with me. When I started there was less contact. They've improved in that way."