A1 Nursing and Homecare Agency Limited

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Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

We carried out this announced 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, and to provide a rating for the service under the Care Act 2014.

A1 Nursing & Homecare Agency Limited is a domiciliary care agency that provides support to adults in their own homes within Wigan and the surrounding areas. At the time of the inspection, 13 people were being supported by the service. One of the people being supported had complex care needs. The agency's office is located near Wigan town centre.

Summary of findings

A registered manager was in place at the agency for the regulated activity personal care. The nurse manager was in the process of registering to become the registered manager for the regulated activity of treatment of disease, disorder or injury. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

We found an effective system was not in place for the management of medicines. The agency had a clear medication policy. However, this was not being applied to how the care plans were written. Appropriate arrangements were not in place to ensure medication was safely administered to people who use the service, which could place them at risk of harm. Staff had not had their competency checked to prompt or administer medications.

A quality assurance system was in place. However, this was not fully effective in all areas of the organisation. Care plans were regularly audited and reviewed. However, some areas had not been kept up to date. For example, there wasn't a way for the registered manager to see whose appraisals and mandatory training was due. This meant it had lapsed for some people. In addition, policies and procedures had not been reviewed and updated for some time, which meant staff did not have access to best practice guidance.

Incidents and accidents were individually identified and investigated. However, there was no overarching system to continuously review the quality of care being provided. This meant opportunities to improve the service further may have been missed.

All the feedback we received from people we spoke with and individual satisfaction surveys we viewed were extremely positive. People told us they were very satisfied with the care and support they received from the agency. In particular, people were happy to receive care from the same care workers and nurses, which they appreciated. We reviewed five people's care packages and found good continuity of care being provided in all cases.

Staff demonstrated an excellent understanding of the needs of the people they supported. We found staff to be warm and caring and genuinely interested in providing care and support that was centred around people's individual needs. We saw examples, of staff going beyond what was expected of them to support people to achieve a good quality of life.

Care plans were clear and comprehensive. They contained guidance for staff about the care and support that people required and also details of people's personal preferences. We saw evidence of people's healthcare and nutritional needs being met.

People were fully involved in their initial assessment, development of their care plan and in the reviews of their care. We looked at one person's care plan who did not have capacity to be directly involved in developing their plan. For this person, their parents took a lead role in agreeing the care plan.

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?

Requires Improvement

The service was not safe, as a clear system was not in place for the safe use and management of medicines. There was a medication policy, however this was not routinely being followed. This meant that people may not be fully protected against the risks associated with medicines.

People told us they felt safe. Staff had a good understanding of how to safeguard the people they supported from abuse. This was because staff had received safeguarding training and could demonstrate how they would identify and respond to abuse. This reduced the risk to people. Staff had been trained in, and had an understanding of the Mental Capacity Act.

We found that staff recruitment was safe with all required checks undertaken. However, this could be strengthened by improving the interview process. Staffing levels ensured care could be delivered safely, and we found people consistently received care and support from the same care workers.

Is the service effective?

Requires Improvement

We found the service was effective. However, staff did not consistently receive their training and appraisals within appropriate timescales. Staff had not had their competency checked to prompt or administer medications.

Staff accessed an induction programme when they started work, which included the opportunity to shadow experienced members of staff. Staff told us they felt well supported day to day within their roles.

People's assessed needs were clearly reflected in the care records we viewed. Care records were clear and provided comprehensive guidance on how people's care needs should be met. Information identified people's personal preferences about how they liked their care and support to be delivered.

Clear arrangements were in place to ensure people accessed health care and received good support to maintain their health or manage existing health conditions.

Is the service caring?

Good

People told us the staff were caring. We observed caring and supportive interactions between staff and the people they supported. Staff treated people with dignity and respect.

We observed that staff had a good understanding of both people's care and support needs and their individual preferences.

People were listened to and encouraged to express their views about their care and support. At regular intervals the registered manager visited people and asked them to feedback about their experiences of the care they received.

Summary of findings

Is the service responsive?

Good

The service was responsive. Changes in people's needs were quickly recognised and appropriate action taken. People's care records were regularly reviewed. This meant that people received safe and effective care.

People felt the service was flexible and based on their personal wishes and preferences. Where changes in people's care packages were requested, these were made quickly and without any difficulties.

There had been no complaints about the service in the last 12 months. People had information about the complaints policy within their homes and told us if they had any concerns at all they would feel confident to raise them with the manager or their carer.

Is the service well-led?

Requires Improvement

Overall, the service was well led however some improvements could be made. The management team promoted strong values and a culture centred around individuals. Staff enjoyed their work and spoke positively about the agency.

There was a quality assurance system in place and this was effective in ensuring care records were regularly audited. However, there had been some slippage in some of the systems used, such as for monitoring appraisals. Policies and procedures had not been recently checked to ensure the agency worked in line with best practice.

Information on individual incidents and accidents was identified, recorded and investigated. However, there were no wider systems to analyse information about the quality of care being provided to look for trends and to continuously improve the delivery of the service.

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Detailed findings

Background to this inspection

We visited the agency on 07 and 12 August 2014. Our inspection team was made up of an inspector from the Care Quality Commission. Before our inspection we reviewed all the information we held about the agency including notifications received by the Care Quality Commission. We contacted the local authority, which commissions care from A1 and Wigan Healthwatch to gather information about the service. On the second day of the inspection we received the provider information return from the service, which we have reviewed alongside the information gathered during the inspection.

During the inspection we visited three people in their own homes. During our home visits we observed the way staff provided support and interacted with people. We spoke with one person's relative on the telephone on their behalf, as they were unable to speak with us directly. We also viewed feedback within people's care records about their views of the care they received. We were unable to send out a questionnaire to people about their experiences as we had not received the information we had requested, prior to the inspection from the service.

We spoke with the registered manager, the owner, the nurse manager, and five care workers. We also spent time looking at records. These included people's care records, staff records and records relating to the management and oversight of the care agency.

Requires Improvement

Is the service safe?

Our findings

People were not protected from risks associated with the unsafe use and management of medicines. We looked at the medication policy in use at the service. This was clear and comprehensive. The policy stated that guidance must be in place within people's care plans as to whether medication was being prompted, administered or administered using specialist techniques. We asked the registered manager about how they ensured the medication policy was being followed by staff. They told us they had not been aware of the contents of the policy as it had been put in place before they had started at the service.

We found the medication policy was not being followed in practice. Information about how staff should prompt or administer medication was not clearly and accurately recorded in people's care plans. For example, one person had complex care needs including a tracheostomy and a percutaneous endoscopic gastrostomy (PEG). Their care plan stated that staff should administer prescribed medication through the person's PEG. We found a prompting sheet was being used to record the administration of medication; this did not include information about the individual medications being administered. This meant staff did not have access to an appropriate system to be able to administer medication safely and accurately record what medication they had administered.

We visited one person in their own home. Their care plan said that carers were to prompt their medication from a blister pack. The person told us they were very reliant on their carer with their medication as their eyesight was now poor and they couldn't see what they were doing. Due to this, in practice the carer was administering the person's medication. Another person had an over the counter cream applied to their legs by staff. The person's care plan did not specify what the cream was, where it was to be applied or how often it should be applied. Therefore, appropriate arrangements were not in place to ensure medication was safely administered to people who use the service, which could place them at risk of harm.

This meant there had been a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

All the people we spoke with said they were happy with the carers that came into their homes. One person said "I have no concerns whatsoever with my care." Another person said "In the past, I had a few problems but for the past couple of years I have had the same carers and I totally trust them. You need to be able to trust people who come into your home."

The service had a safeguarding policy in place, which was undated. This policy was designed to be used in conjunction with the local authority's safeguarding procedure, a copy of which was stored in the safeguarding file. Of the 17 staff who worked at the service, 14 had received safeguarding training in the last two years. We spoke with the registered manager, and three care workers about safeguarding. All were able to describe situations that could constitute abuse. The care workers said if they identified abuse, they would raise this with the office. The registered manager told us they would report any allegations of abuse to the local authority, and notify the Care Quality Commission. No safeguarding concerns had been identified in the last 12 months. This meant that arrangements were in place, and being used, to keep people safe from abuse and avoidable harm.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA). The MCA provides legal safeguards for people who may be unable to make decisions about their care. The registered manager demonstrated an understanding of the MCA. Training records showed that staff had received training in the MCA.

We found risks were identified, assessed and managed in a way that protected people effectively. We looked at five people's care records and found these contained risk assessments for areas such as nutrition, falls and pressure care.

We looked at the recruitment records of two care workers and one nurse. Appropriate recruitment checks were undertaken before people started to work for the service and these were clearly recorded. Checks included: two references, identification checks, and a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to prevent unsuitable people from

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Is the service safe?

working with children and vulnerable adults. For one person, who had been recruited a number of years earlier, an issue had been missed. However, this had subsequently been identified and resolved.

We found people were not consistently being interviewed to assess their suitability for their role. When interviews did take place, the information gathered to reach a decision was limited. We discussed this with the management team, who told us they would review their recruitment process with an aim to strengthening practice in this area.

The registered manager provided us with information that showed there had been no missed calls / visits to people using the service in the last 12 months. We looked at staffing levels across the service and found people consistently received care from the same care workers and nurses. This meant that people received the care and support they required to keep them safe. People told us they were very happy with the consistency of care they received.

Requires Improvement

Is the service effective?

Our findings

We saw that each person who requested support from the agency, had a full assessment prior to the service starting. From the assessment a care plan was developed that covered people's care and support needs. The registered manager told us that people were fully involved in deciding what care and support was required. We reviewed five people's care records and found detailed information was present about people's care and support needs. In addition, contact details were present for other healthcare professionals that were involved in their care. People told us they felt involved in their care.

We saw evidence people attended routine appointments with a range of health care professionals. For one person, who we visited in their own home, their regular care worker supported them to organise and attend all their healthcare appointments. They kept records of all the appointments and had engaged closely with the community matron and GP to ensure their healthcare needs were effectively coordinated.

The majority of people who used the service did not have specific nutritional needs. One person, had trouble eating and swallowing and had a low body mass index. This meant it was important for the person to have specific support from staff to ensure their nutritional needs were met. The person's care plan had been developed from their Health Action Plan dated July 2014 and described in detail how staff should support them to eat including the required texture of the food. The registered manager had requested further advice from the person's social worker about whether they required a further referral to the Speech and Language Team (SaLT) or the dietician and was awaiting a response.

The staff we spoke with told us they felt well supported. One person said "I really enjoy my job and if I have any questions there is always somebody you can ring to ask." Another person said, "I love going to do my visit. The person I support is very independent so I like that we can spend time doing things together." Staff told us there was an emergency number so if there were any immediate concerns they could access urgent advice.

New members of staff undertook an induction programme, which included three days of mandatory training with associated work books for completion. Following this people shadowed experienced members of staff. We spoke with one member of staff who had worked for the agency for less than a year. They were very positive about the support they had received when they started work.

The nurse manager told us staff should have mandatory training updates and appraisals once a year. Staff did not receive supervisions throughout the year, although staff did tell us support was available if they needed it. We found mandatory training had lapsed for three people, and five people had not received their yearly appraisal . However, on the second day of the inspection the nurse manager showed us records that confirmed that people who had training and appraisals outstanding would attend for this within the following four weeks.

The medication policy stated that staff should be competent to prompt or administer medication in line with the needs of the people they supported. We asked the nurse manager to show us their records of staff competency assessments. The nurse manager told us they were not aware competency assessments were required, and that staff competency had not been assessed. They assured us they would take steps to address this as soon as possible.

Good

Is the service caring?

Our findings

Staff had developed caring and positive relationships with the people they supported. During the visits we made to people in their own homes, we observed good interactions between staff and the people they supported. This was confirmed by all the people we spoke with. One person said, "I think I am getting good care here. I wouldn't want any changes at all." Another person said "I've never had any trouble. They are great." A relative said, "It is smashing they are brilliant."

People told us the staff were kind and treated them with respect. One person said; "The carers that come to me are really helpful. They are always willing to be flexible and they work around whatever it is that I need." They went on to describe how if at any point another carer had to come that somebody always lets them know in advance. In addition, if anybody was running late they always called to let them know.

All the staff we spoke with during our home visits demonstrated an excellent understanding of the needs and preferences of the people they supported. For example, one care worker described how they had supported one person to go to a community event and they had heard about a service that may be beneficial to the person. They had then spent time ringing around to determine how to access this service and had managed to get the person an appointment.

The family member we spoke with told us that the regular nurses and carers that came knew their relative extremely well, and were able to respond to their body language. They said it was very important to their relative that care was delivered in a specific way that suited their relative or it could be very distressing for them. They felt that because the same regular carers came they were able to provide care in a way they could rely on, which gave them the confidence to go out the house for a few hours without worrying. We looked at this person's care plan and found it to be very detailed with clear information about the person's individual needs and preferences.

Care staff we spoke with explained to us how they made sure people received help with their care in a way which respected people's choices and responded to their needs. For example, one member of staff chose to arrange their hours around the healthcare appointments of the person they supported. We were told that induction training covered respect and dignity. In addition, there was a policy in place about the values that were expected of staff. Information was also available in the staff handbook that each member of staff received during their induction.

Good

Is the service responsive?

Our findings

People told us they were involved in decision making about their care and support. One person said "I know all about the care plan and have signed to show I'm happy about it." One relative said, "We were asked about the care needs of my son and were fully involved in the development of his care plan. We then agreed it and it was signed off." In this instance this was of particular importance as the person's family members were their primary carers and therefore had a comprehensive understanding of the person's needs.

Two of the 13 people supported by the agency did not always have capacity to make significant decisions about their care. Both people had family members that were their primary carers and that played a lead role in their care. Due to this, the agency had not had to access advocacy for anybody or manage a best interests decision making process.

Reviews of people's care were being carried out regularly, the frequency of reviews depended on the person's care package. For example, the person who had complex care needs had their care plan reviewed monthly, whereas for other people it could be three monthly. If a person's needs had changed the care plan would be reviewed as needed. We checked five people's care plans and found that all had been reviewed within these time frames. We spoke with the nurse manager who explained to us how they used temporary care plans when needed and showed us examples of how they had used these within a complex care package. This meant staff had up to date guidance available to them about how people's care and support should be delivered.

Staff we spoke to demonstrated a commitment to people having choice and control about how they spent their time. We found staff offered support and encouragement to people to access the community where people had care hours for social support. Staff were flexible in how they worked to respond to people's requirements. People told us the communication from the office was very good, particularly in relation to changes to staff attending to provide care and also to advise that a staff member would arrive late. This meant the service was organised around people's needs.

Information on how to make a complaint was available in a handbook stored in people's homes. We viewed one of these on one of our home visits and found it contained appropriate information. The registered manager told us they tried to resolve any minor concerns quickly so they did not escalate to a formal complaint. All the people and family members we spoke with said they didn't have any concerns. However, if they did they knew how to complain and told us they would feel confident to do so if necessary.

The manager showed us a copy of the complaints procedure in the office, which was not dated. This had limited information in it about how the service would respond in the instance of a complaint. For example, there was no information about timescales for response or about the role of the Local Government Ombudsman. The manager told us they would review and update the policy to bring it in line with the information present in the handbooks in people's homes.

There had been no complaints made about the service in the last 12 months. The last complaint received by the service had been in April 2013. We viewed this complaint and found it had been investigated and appropriate action had been taken to resolve the issue raised.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place at the agency for the regulated activity personal care. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The nurse manager was in the process of registering to become the registered manager for the regulated activity of treatment of disease, disorder or injury. The nurse manager was responsible for training within the agency and for managing the care package of the one person with complex care needs.

The agency did not have a provider level audit system for checking the quality of care within the service. At the time of the inspection, the management team could not demonstrate how they bring together all the information held about the service to consider the quality of care and to continuously look for areas for learning and development. Due to this, there were some areas where practices had slipped past the management team. For example, the system used for checking people's appraisals, mandatory training and nurse pin numbers had lapsed, which meant a number of people had not had these scheduled in advance. In addition, as the medication system had not been reviewed, the management team had not ensured current practice was in line with the agency's medication policy. Staff were delivering medication when they had not been signed off as competent to do so, which could place people at risk of harm. Medication audits were not in place.

This meant there had been a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Care plans were regularly reviewed and all daily records were brought back to the office regularly and audited before being filed. Spot checks of staff within people's homes were used to ensure staff were on time, dressed appropriately, and that they delivered care in line with the care plan.

People were encouraged to express their views about their care and those views were listened to and respected. The manager told us they checked the views of people and their family members about the quality of care and support provided during their reviews. We checked five people's care records and found this to be the case. Comments included; "We are very happy with the support from the carer"; and "Very satisfied with her regular carers. No problems." However, no wider analysis was completed of the satisfaction surveys that were collated throughout the year.

Incidents and accidents were identified, investigated and reported appropriately. We tracked one accident that had recently occurred and found this had been fully reviewed and signed off with no further actions needed. When incidents or accidents had been investigated and signed off they were filed within people's care records. There was no system in place to centrally collate incidents and accidents so they could be reviewed for any trends or patterns.

We found there was a positive culture within the organisation, and that staff were committed to delivering good quality care. The registered manager, nurse manager and nominated individual worked together as a team to manage the service. Leadership within the service was good. However, this could be developed further particularly around clarifying and strengthening the roles and responsibilities within the management team.

There was no senior carer role within the service. A care coordinator had been in post for a few days at the time of the inspection and was in the process of learning what their job entailed. This meant that in the time leading up to the inspection, the registered manager had focused their time on coordinating the delivery of care, reviewing people's care plans and undertaking spot checks. They also at times directly covered calls to people who used the service. The registered manager told us as the new care coordinator could take on more of the coordination role independently it would free up their time for working on other areas within the service.

We saw that the agency had a full set of policies and procedures that covered a wide range of topics including equality and diversity, medication and recruitment. These were not dated and the information contained within them, in some cases required review as it was out of date. The registered manager showed us the staff handbook; this had been updated regularly and contained key policies that had been updated that were different to those in the office file. The registered manager told us they were unsure when the policies in the office file had last been reviewed to check they were in line with both best practice guidance

Requires Improvement

Is the service well-led?

and with what was currently expected of staff employed by the agency. They said they would look to start reviewing policies on a rolling basis and would introduce a version control system.

The agency had a whistleblowing policy, which was available to all staff. We spoke to staff about what they would do if they had any concerns. They told us they would not hesitate to report anything they thought was not right and were confident the matter would be investigated and dealt with by the management team.

Staff told us they felt well supported and there was always somebody they could get in contact with if they had any queries. Staff were employed via zero hours based contracts and were not paid travel time between calls. We found the majority of the care workers worked directly with the people they supported and would come to the office if they were due to receive a mandatory training refresh or their appraisal. Staff meetings were not held by the service at either care worker level or management team level.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person did not protect service users against the risks associated with the unsafe use and management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **An effective system was not in place to regularly assess and monitor the quality of the service provided.**