Age Concern Kensington & Chelsea

Age UK Kensington & Chelsea At Home Service

Inspection report

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25 January 2019

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This announced inspection was carried out on 13 and 21 December 2018. We completed inspection activity on 25 January 2019. We gave the provider two days' notice of the inspection to make sure that key staff we needed to speak with were available. The service was rated as Good at the previous inspection in May 2016. At this inspection we have rated the service as Requires Improvement.

Age UK Kensington and Chelsea is a domiciliary care agency which provides the regulated activity of 'personal care' to people living in their own houses and flats in the community. Not everyone using Age UK Kensington and Chelsea receives regulated activity. The Care Quality Commission (CQC) only inspects the service being received by people provided with personal care; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection the provider was providing services for 47 people, which included 27 people who received personal care.

A registered manager is a person who has registered with CQC 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 the time of the inspection the manager had appropriately applied to CQC for registered manager status.

We found the provider did not always have detailed risk assessments in place to identify risks to people's safety and well-being. For example, staff had recorded their concerns about a person's skin integrity in their daily visit sheets but this was not reflected in the person's risk assessment.

Recruitment practices did not always demonstrate that references for staff were checked to ensure they were genuine, to ensure that people who used the service consistently received care and support from staff with appropriate skills and background to work for the provider.

People who used the service felt safe with staff, who had received training to protect people from the risk of abuse and harm. Staff were also trained to protect people from the risk of cross infection and were provided with personal protective equipment to use at people's homes.

Staff told us they felt well supported by the management team. Records demonstrated that staff had received induction, mandatory training, individual and group supervision, and annual appraisals. Team meetings were also held by the manager to bring staff together for discussions about their work and development.

Where required staff supported people to meet their nutritional needs and attend health care appointments. People were supported to meet their medicine needs where this formed part of their agreed care plan. Staff informed us they reported any concerns about a person's health to their line manager so

that applicable health care professionals could be informed.

The provider understood how to protect people's rights and supported people to make choices about their care and support in line with their capacity to do so. People were supported in a respectful manner that promoted their dignity. Staff understood how to meet people's religious and/or cultural needs. People and relatives liked receiving their care from a limited number of conscientious and reliable care staff that they got to know well.

The care plans were being reviewed and updated by the manager to ensure that people's needs and wishes were described in a more individual and detailed manner. We noted that some plans needed more written guidance for staff to provide care and support that was tailored to people's unique needs and aspirations. People and relatives were given information about how to make a complaint. We saw that where complaints and safeguarding investigations had occurred, the provider carried out its own analysis to identify and address shortfalls in how the service operated.

People and relatives expressed they thought the service was well managed and they liked the openness of the manager. We saw that quality assurance systems were in place but the provider had not picked up on specific issues that needed to be improved on, that we found during the inspection. For example, we found that the on-call records needed to be written in a more precise and professional manner. The provider had created its own action plan and fully acknowledged that improvements were needed.

There were well developed working relationships with other local services, which enabled the provider to continually develop its own knowledge and offer people who used the service new opportunities to meet their health care needs and social interests.

We found three breaches of regulation in relation to safe care and treatment, recruitment and good governance. You can see what action we asked the provider to take at the end of the full version of this report.

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 always safe.

Risks to people's safety were not always identified and mitigated.

Staff recruitment practices were not sufficiently rigorous for the provider to be assured that newly appointed staff had suitable experience, knowledge and background to work with people who used the service.

Staff provided a reliable and punctual service.

Staff had training and guidance to understand and detect abuse, and the measures to take to protect people.

Is the service effective?

Good

The service was effective.

Staff received appropriate training, supervision and support to meet their needs.

People were satisfactorily supported by the provider to meet their health care and nutritional needs.

Staff respected people's rights to make their own decisions where possible.

Is the service caring?

Good

The service was caring.

People and relatives thought they received thoughtful and compassionate care.

People's needs and wishes were met by care staff they were familiar with.

The provider assisted people to access independent advocacy and other support, if people wished to.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care planning was not always undertaken in an individual way that responded to people's identified personal care and health care needs.

People and their relatives reported they were pleased with how staff provided care and support.

Suitable systems were in place to respond to any complaints. The provider learnt from complaints where people and/or their relatives had not received satisfactory care and support.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Positive views were expressed by people, relatives and care workers about the manager's approach. However we found shortfalls in the management of the service.

Quality monitoring tools were used but did not always identify the areas for improvement we found during the inspection.

The provider had already developed an action plan to improve the service, based on its own audits and findings prior to this inspection.

The provider worked positively with other local services that supported older people and their informal carers.

Age UK Kensington & Chelsea At Home Service

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 announced inspection was conducted on 13 and 21 December 2018 by two inspectors on the first day and one inspector on the second day. Inspection activity was concluded on 25 January 2019. We informed the provider 48 hours before our visit that we would be coming we needed to be ensure that a member of the management team was available to participate in the inspection.

Prior to the inspection the provider completed a Provider Information Return (PIR) sent by the Care Quality Commission. This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including the previous inspection report for May 2016 and notifications sent to us by the provider about significant incidents and events that had taken place at the service, which the provider is required to send to us by law.

During the inspection we spoke with a dementia support worker, the basic footcare coordinator, the manager and the chief executive officer. We looked at a range of records which included four care plans for people who used the service, medicine administration records, the complaints log, five staff files for recruitment, training, supervision and appraisal, minutes for team meetings and quality monitoring documents.

Following the inspection, we spoke by telephone with two people who used the service, the relatives of two other people and three care workers. We contacted four health and social care professionals with knowledge of the service and did not receive any comments.

Requires Improvement

Is the service safe?

Our findings

The care plans we looked at showed that individual risk assessments had been devised to protect some people who used the service through identifying risks to their safety and wellbeing. However, we found that the provider had not ensured that there were sufficiently comprehensive risk assessments in place for each person who used the service.

For example, the daily records for one person demonstrated that care staff were applying cream to a person's skin as there were concerns about their skin integrity. However, there was no mention of any risks to the person's skin integrity in their risk assessment or their care plan for personal care. The care file for a second person stated they were diagnosed with a dermatological condition but there was no information recorded as to whether this condition presented any risks to the person's skin integrity and whether care staff needed to observe for any specific changes in their skin condition. A third person had experienced falls but the initial record keeping when the falls first occurred was not sufficiently detailed for us to determine if the risk assessment related to their mobility needs was promptly reviewed and updated. We noted that environmental risk assessments were in place to identify and mitigate risks to people's safety due to factors including unnecessary clutter and loose wires in their homes. The provider offered a free 'Simple DIY Service' that people who used the domiciliary care service could access, which supported people to reduce the occurrence of falls and slips at home caused by issues such as frayed carpets or inadequate lighting. However, the care plan for one person who lived in a flat above the ground floor did not contain written guidance for staff about how to evacuate them from their home in the event of an emergency.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment practices were not always sufficiently robust. The staff files we looked at demonstrated the provider obtained two references and checked proof of identity, proof of address and proof of eligibility to work in the UK, apart from one file where the references were missing. This had been identified in the provider's own recent audit but not resolved. All staff had undertaken a Disclosure and Barring Service (DBS) check before they commenced work. The DBS provides criminal records checks and barring functions to assist employers to make safer recruitment decisions. We had noted at the previous inspection that the recruitment files had not evidenced the provider consistently verified references to determine their authenticity. At this inspection we found that where staff were appointed since the previous inspection, references were not always verified.

This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider ensured that new staff were provided with induction training and opportunities to shadow experienced colleagues, which was confirmed by staff training records. A staff member told us, "Going out for three days shadowing and the training I was given really helped me to understand how to support my clients."

Most people who used the service did not require support from care staff with managing their medicines. Records showed that staff had received medicines training and medicine administration records (MARs) were audited by the manager to ensure that people were safely supported with their medicines, in line with their assessed needs. We spoke with members of the care staff team about their responsibilities when prompting or assisting people with their prescribed medicines and found they had suitable knowledge of the provider's medicine policy. However, when we looked at the daily records for one person who used the service we found they were now being assisted by care staff although their care plan stated they were still independent with this task. Therefore, the care plan was not up to date, a medicine risk assessment had not been developed and there was no medicine administration record (MAR) in place. We discussed this finding with the manager on the first day of the inspection and noted this was appropriately dealt with by the second day of the inspection. The manager showed us an action plan she had developed to reassess the medicine support needs of people who used the service by the end of January 2019, to ensure that any potential changes to their circumstances were detected and addressed.

People and their relatives where applicable informed us that the care workers were trustworthy and supported them to feel safe. One person said, "Yes, I feel safe with [names of care workers]. They come on time and are very nice. They ask me what I want and will always do their best to help me." A relative told us, "This agency is our first choice. The staff are extremely helpful and we trust them. There has never been anything worrying and we have been using [service] for a number of years."

The care staff we spoke with presented a clear understanding of how to identify different types of abuse and how to protect people from abuse and harm. Staff were familiar with the provider's safeguarding policy and procedure, and explained to us that they would immediately report any concerns to their line manager if they had any safeguarding concerns about a person they supported. Staff knew how to whistle blow within the organisation and externally if necessary, in line with the provider's whistle blowing policy. Whistleblowing is when a worker reports suspected wrongdoing at work.

We spoke with the manager and the chief executive officer about safeguarding investigations carried out by the local authority since the previous inspection. We noted that the provider had undertaken a detailed internal investigation where necessary and implemented a robustly designed action plan to ensure that applicable learning and improvements took place within the organisation.

People and relatives informed us that they received a punctual and reliably delivered service. One person who used the service told us they received their care and support from a few care workers they had got to know and this consistent approach was also commented on by the relative of another person. People described staff as being 'dependable' and confirmed that they stayed for their allocated time. The manager stated they were planning to introduce an electronic monitoring system in 2019 which would allow staff to record on a mobile phone device they had arrived at a person's home and had completed the delivery of people's care and support, in accordance with their agreed care plan. This system would enable the provider to more closely monitor that people received a safe and stable service.

Accidents and incidents were recorded and systems were in place for the manager to analyse these records to identify any trends.

Records showed that staff had received infection control training to protect people from the risk of cross infection. Staff told us they were provided with personal protective equipment and it was readily available to collect from the main office. One care worker said, "We are given disposable gloves, aprons and shoe covers. We get infection control training every year. It is about how we provide personal care and also how to work safely if we are preparing a drink or food for a person in their kitchen."

Good

Is the service effective?

Our findings

Clear systems had been established to ensure that people's care and support was delivered in line with current legislation and standards. The chief executive informed us that policies and procedures were regularly reviewed and updated to reflect any current changes. The sample of policies and procedures we looked at were up to date. For example, the provider's medicines policy and procedure was written in line with 'The Handling of Medicines in Social Care' professional guidance document from the Royal Pharmaceutical Society of Great Britain.

People and relatives told us that staff understood their needs and had the right skills and knowledge to meet their needs. One person who used the service told us, "Yes, they (staff) do everything very well, I have no complaints." Records showed that staff had received relevant training for their roles and responsibilities, which included moving and positioning people, basic food hygiene, health and safety, equality and diversity, safeguarding vulnerable adults and dementia care. Staff told us they felt well supported by the provider through the training programme, one to one formal supervision, staff meetings and an annual appraisal of their performance and development needs. Some staff had already attained national qualifications in health and social care, and new staff were offered opportunities to undertake recognised qualifications. One member of the staff team told us the manager had spoken with them at their most recent one to one meeting about available opportunities to develop their knowledge and skills through vocational training.

At the time of the inspection the service was providing a basic foot care service within the local borough. We spoke with the provider's basic foot care coordinator and a care worker who was trained to carry out this care. Staff assigned to this scheme told us they had attended a short intensive training course delivered by a podiatrist, which they had found very useful. Following the inspection visit the manager informed us that the funding for the basic foot care service was due to be withdrawn.

Where people who used the service required support from staff with preparing meals and drinks, this was recorded in people's care plans. At the time of the inspection the service was not supporting any person who was at risk of choking when eating and/or drinking or had any complex dietary needs. The chief executive officer told us that the provider had benefitted from having dietitian students on placement who had developed tools to support people with long-term conditions to meet their nutritional needs. The provider also operated initiatives that people who used the service could attend to increase their knowledge of healthy eating and join other people for sociable dining. This included nutrition workshops and the 'food and friends project' at local Age UK luncheon clubs.

The provider demonstrated that it worked in partnership with local organisations to improve people's wellbeing. The chief executive officer told us about the provider's partnership working with the local NHS, known as the 'My Care, My Way' scheme. The provider employed approximately 40 health and social care assistants to work at GP services in the borough to support older people to coordinate and identify their health care needs. The chief executive officer told us that this scheme had enabled the manager and staff team at the domiciliary care agency to develop beneficial links with the health and social care assistants along with the wider community health care team. For example GPs, district nurses, physiotherapists and

occupational therapists at falls prevention services, and tissue viability nurses.

From our discussions with people who used the service and relatives, we found that people were supported by their relatives and friends to attend GP appointments and access other professional health care support. The provider operated a borough wide scheme where people could be supported by Age UK to attend health care appointments, in line with their needs and wishes. Care staff told us they reported any concerns in relation to people's health and wellbeing to their line manager. The manager demonstrated that these concerns were discussed with people who used the service, their relatives, chosen representatives and/or social worker if applicable, so that prompt contact could be made with their GP or other health care professional.

The provider had systems in place to ensure that people who used the service were supported to make their decisions in accordance with legislation and guidance. 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. Staff had received MCA training and told us they would always ask people for their consent before they provided personal care. The care plans we looked at demonstrated that people who used the service were encouraged to sign their care plan where they had capacity. The manager was aware of the need to obtain a copy of the Lasting Power of Attorney (LPA) document where relatives stated they held the legal authority to sign care plans on behalf of their family member. The provider's MCA policy provided guidance for staff in relation to circumstances where it may be necessary to make best interests decisions with people's relatives and other professionals if people no longer had capacity to do so.

Good

Is the service caring?

Our findings

People and relatives reported that the care workers were kind and caring. One person told us, "They are all very pleasant and have a nice way of doing things" and a relative told us, "[My family member] is very happy with the carers. They are delightful and caring people."

During our discussions with people who used the service and relatives we found that people felt they had been consulted about how they wished their care and support to be delivered. Relatives told us they liked the service because their family members were provided with a flexible and individual package of care. However, the current format for care planning did not capture this level of consultation. The manager acknowledged that the care plans needed more information to demonstrate that people were asked about their personal histories, likes and dislikes and had commenced the process of updating the care plans to ensure this was prominently featured.

The provider arranged rotas so that people who used the service received their care from a limited number of care staff. This enabled people to feel comfortable with staff and develop positive relationships with them. The care staff we spoke with conveyed a genuine warmth for the people they regularly supported and described their work as "rewarding" and "fulfilling."

Staff told us how they met people's cultural and/or religious needs. For example, one staff member told us they used to visit a person where it was necessary to remove their shoes before they entered the person's home. They also provided an example of how they supported a person who used the service in a non-judgemental manner. We saw that in some circumstances the provider matched people with care staff who spoke the person's first language where it was not English. During our discussions with staff we learnt that this had worked particularly well when a person formerly spoke English but had returned to speaking their first language due to dementia. People were consulted about whether they wished to be supported with their personal care by a care worker of the same gender and their wishes were respected.

Records showed that staff had received training in relation to providing personal care that promoted people's entitlement to dignity and privacy. Staff told us they ensured that people were supported with their personal care in a private room where they could not be observed by other people, for example staff pulled curtains and closed doors. One care worker told us that it was particularly important for a person they supported to be momentarily left alone to carry out aspects of their personal care, in accordance with their wishes.

Confidential information about people was stored securely at the provider's office. When we contacted care staff after the visit to the service they informed us they were in a private area to speak with us and did not refer to people who used the service by their names.

The provider could refer people to independent advocacy services if they needed support to make a complaint about the quality of care they received from the domiciliary service, or any other health or social care organisation they used. Age UK Kensington and Chelsea operated a free information and advice service

for older people in the borough, which could be accessed by people who used the service.

Requires Improvement

Is the service responsive?

Our findings

Although the people and relatives we spoke with were happy with how the provider assessed and met people's needs, some care plans we looked at lacked sufficient detailed information to demonstrate that care workers were provided with the written guidance required to deliver an individual and responsive service. For example, one care plan we looked at had not been updated to demonstrate that the person's care package had been increased. The care plan listed tasks that needed to be carried out but did not provide enough details about how the person wished to be supported.

We noted that as a local voluntary sector organisation, Age UK Kensington and Chelsea operated different schemes to support people living with dementia, for example twice monthly Memory Cafés and an Exercise for the Mind group. During the inspection we spoke with a dementia support worker about their role carrying out weekly visits to support people and their relatives, and they provided examples of work they had undertaken to support people and their relatives to cope during difficult times. People could also access support from the organisation's dementia advisors about how to navigate local services if they were recently diagnosed with dementia. However, the organisation's expertise, experience and responsive approach in dementia care was not always visible when we looked at the care plans for people who used the domiciliary care agency. One care plan for a person living with dementia did not contain any information about the type of dementia and how it impacted on the person's daily life and behaviours. For example, how care staff could support the person if they appeared distressed or withdrawn, and how to encourage the person to engage as much as they were able to during visits.

A third care plan we looked at was for a person who received a small care package for personal care and was also supported by staff with administrative tasks, for example dealing with household bills. This care plan demonstrated that the person's individual needs were fully understood by their regular care worker and a positive relationship had been established.

The provider's own action plan showed that the care plans were presently being reviewed and revised. Where applicable, the provider had carried out assessments of the needs of people's carers so they could signpost them to available local services that offered support and respite. The carers' assessments that we saw were well written.

The manager was aware of their responsibilities in relation to the Accessible Information Standard (AIS). Since 1 August 2016 all organisations that provide NHS care and/or publicly funded adult social care are legally required to follow the AIS. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services and their informal carers with a disability, impairment or sensory loss. Where necessary the provider was able to arrange for people to receive information about the service in different formats, for example in large print or audio.

Systems were in place to advise people, relatives and any other individual or parties about how to make a complaint about the quality of the service. A person who used the service stated they had never had cause

to make a complaint and felt the manager would take any complaints seriously. Prior to the inspection we were informed by the relative of person who formerly used the service that they were dissatisfied with how the provider had investigated a complaint they raised which then progressed to a safeguarding investigation. We noted the provider had carried out its own analysis of what went wrong to learn from mistakes and implement measures to improve outcomes for people who used the service. The relative of a person presently using the service told us they had raised a concern and were pleased with the provider's response. We looked at the provider's complaints log and discussed with the manager how they had responded to complaints.

At the time of the inspection the service was not providing end of life care as this was not required by people who used the service.

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us they thought the service was managed properly and they spoke positively about the manager. One relative stated "[The manager] is a lovely person and has been very helpful on the occasions I have telephoned the office." The care staff we spoke with all felt well supported by the manager and supervisory team. Although we received positive comments about the supportive and approachable leadership style at the service, we found shortfalls in specific areas. For example, the robustness of the provider's risk assessments and processes for ensuring safe staff recruitment. We also noted that the provider did not always maintain accurate and complete records in relation to some people's care plans.

The provider evidenced that there were systems in place to monitor and assess the quality of their service, which included 'spot check' visits to people and the use of satisfaction surveys to seek their views. The manager audited the visit sheets completed by care staff to check that people's care and support was delivered in a respectful manner in line with people's assessed needs, and whether care staff had promptly reported to their line manager any concerns about people's safety and wellbeing they had documented in these records. However, we noted that the most recent visit sheets produced for one person who used the service were dated January 2018.

We looked at the on-call log and found that it was difficult at times to comprehend. There were missing weeks and sometimes incomplete dates so we couldn't workout which year entries referred to. Designated on-call staff did not always appear to record information in a professional way. For example, an on-call worker wrote on one occasion that they hadn't immediately followed up a concern raised by a care worker as they were having a coffee with a relative. We discussed this with the manager who acknowledged that although some of these entries could have been made by staff who no longer worked for the provider, there was a need to discuss standards for professional record keeping with supervisory staff.

These findings constituted a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider had carried out an audit of its systems and practices, and created an action plan in consultation with the organisation's board of trustees. We saw the chief executive officer and manager were working towards meetings its objectives for improvement at the time of the inspection.

As part of a well-established local voluntary sector organisation, the provider had developed links with a wide range of other organisations within the borough. This included statutory bodies including the local NHS, who were funding the basic foot care service at the time of the inspection. Ongoing work with health care partners was taking place through the 'My Care, My Way' scheme. Other links had been formed to enable people who used the service to maintain their independence and promote their social wellbeing, for example through a digital inclusion project and entertainments organised with Holland Park Opera and the Royal Albert Hall.

In accordance with legislation, the provider informed then Care Quality Commission of notifiable events and

displayed its current ratings on its website

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's needs must be assessed to identify risks to their health and safety. 12(1)(2)(a)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality checking arrangements did not consistently assess, improve, monitor and sustain the quality of experience for people who used the service. 17(1)(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not establish and operate effective recruitment procedures. 19(2)