A1 Medical & General Ltd

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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**

Summary of findings

Overall summary

We undertook an announced inspection of A1 Medical & General Ltd on 5 August 2018. We gave the registered manager short notice that we would be coming because the location provides a domiciliary care service and we wanted to ensure the registered manager was available.

A1 Medical and General is a nurse agency providing nursing and care services to private and NHS hospitals, prisons, nursing and care homes. The service is also registered to provide domiciliary care services and supported living services. The office is based in Doncaster and is close to public transport links.

Not everyone using A1 Medical & General Ltd receives regulated activity; 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 our inspection the service was supporting two adults and two children with their personal care needs.

The last inspection of A1 Medical & General Ltd was on 1 September 2016 when the service was rated 'Good'. At this inspection the service was rated 'Requires Improvement'. This is the first time the service has been rated 'Requires Improvement'.

There was a manager at the service who was registered with CQC. 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 and associated Regulations about how the service is run.

Although staff were aware of potential risks to people who used the service and others, information regarding risks was not available in people's homes. This meant staff had no guidance to refer to and assist them with making decisions about risks.

People told us they felt safe in the care of the staff. Staff had a good understanding of abuse and their responsibilities in keeping people safe. However, safeguarding concerns were not always reported through the agreed safeguarding protocols to ensure people were protected from abuse and avoidable harm.

Our observations evidenced there were enough staff on duty to meet people's individual needs.

Checks were carried out prior to staff being offered a job at the service which helped to ensure people being employed were of good character.

Staff worked effectively with other organisations to ensure people's needs were met. People were referred appropriately to health care services if their care needs changed. However, a detailed written plan of care for staff to read and refer to was not available in each person's home.

Staff were supported to receive the training and development they needed to care for and support people's individual needs. However, staff were not provided with a planned programme of one to one supervision and felt the support they received from the registered manager had recently deteriorated.

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

People were positive about the care they received from the care workers and told us the staff were kind. Staff were cheerful and treated people with respect and kindness throughout our inspection. Healthcare professionals spoken with talked positively about the quality of care provided to people and said they had no concerns about this service.

The registered manager ensured regular staff who were known to people would attend visits which meant consistent care and support was provided to people.

There was a system in place for people and their advocates to report their concerns. People told us they could talk to the care workers about any worries or concerns and these would be dealt with quickly.

The registered manager had a good insight into the quality of care being delivered and monitored the service personally. However, further improvement was needed in the quality assurance processes to identify shortfalls in people's care records and drive improvement.

Recorded evidence of the auditing and monitoring of the service needed to be embedded into management systems. The registered manager was committed to looking at the issues raised by the staff in relation to communication within the team and everyone's responsibility for this.

Further information is in the detailed findings below.

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.

Written risk assessments were not always kept in people's homes which could put people's health and wellbeing at risk.

Safeguarding concerns had not always been reported through the correct procedures to ensure people were safe.

Medication administration records were fully completed which helped to ensure people received their medicines safely.

Enough staff were employed to meet the needs of people who used the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People's physical, mental health and social needs had been assessed, however information relating to their needs was not always recorded in a plan of care.

Staff had not been provided with formal one to one supervision in line with the services policy.

People were supported with their personal care by staff who were trained to meet their needs.

Staff had a good understanding of the principles of the MCA and incorporated these in their work.

Is the service caring?

Good

The service was caring.

People received care from staff who cared about them, liked and respected them. Staff developed relationships with people and took the time to get to know them individually.

Staff were respectful of people's own decisions and encouraged them to retain and develop in their confidence and levels of

independence.

Is the service responsive?

Good

The service was responsive.

People were supported by staff who were knowledgeable about their support needs and were responsive to any changes in their well-being.

People were confident any concerns they raised with the registered manager or staff would be dealt with promptly.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager had a good understanding of all aspects of the service. However, the systems to monitor parts of the service were not always effective.

The management team were developing and embedding comprehensive systems of oversight and quality improvement.

The service had a full range of policies and procedures which staff were aware of.

A1 Medical & General Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 August 2018. We gave the service two days' notice of the inspection because we wanted to visit people in their homes and we needed support from the registered manager to arrange this. At the time of our inspection the service was supporting four people.

The inspection team consisted of one adult social care inspector. We visited two people in their homes to ask their opinions about the care they received and look at their care records. Whilst out on visits we were accompanied by the registered manager and met with one care worker.

We visited the office location to see the registered manager and office staff and reviewed care records and policies and procedures relating to the service. We looked at four staff training, support and employment records. We also spoke over the telephone to three care workers and received information from one care worker via e-mail.

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

Prior to the inspection visit we gathered information from many sources. We looked at the information received about the service from notifications sent to the Care Quality Commission by the registered manager. We also spoke with the local authority commissioners, contracts officers and safeguarding and Healthwatch (Doncaster). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe when the care workers were in their home and did they trust them when providing personal care. People told us they did feel safe when being cared for. Their comments included, "The care workers are lovely, great, I like them all" and "Yes they are good."

Whilst out on visits we observed staff providing care and support to people in a safe way. Staff were aware of each person's specific needs and how these could be supported in a safe way. Only a small team of regular care workers were providing personal care to people and it was clear staff knew people well. Staff spoken with were able to explain in detail the potential risks identified for each individual. For example, one person had asked to go swimming. Staff were able to talk through the discussions they had with the registered manager regarding risks to the person during a swimming activity. However, when we looked at people's support plans we found there was no written information regarding potential risks that people who used the service and staff could be subject to. When we asked the registered manager about this she told us there were copies of risk assessments in the office but these were not in people's homes. This meant although staff were knowledgeable about people's individual risk areas they did not have information to refer to if they were unsure about something. It also meant if non- regular staff, who were not as familiar with the person, were called upon to provide care they would not have written guidance about how to provide safe care and minimise or eliminate known risks.

Following the inspection, the registered manager confirmed to us that risk assessments relating to all aspects of people's care had been placed in people's homes.

Staff spoken with told us they had received training in safeguarding adults and children and had a good understanding of their responsibilities for keeping people safe. Office based staff had also completed safeguarding training so they would have the skills to recognise any potential safeguarding concerns from telephone calls received to the service. Staff knew what action they would take if they had any concerns about people's safety and welfare.

When we spoke with the registered manager she told us of several incidents involving two people who used the service. The registered manager believed these should have been reported to the local authority safeguarding department. The registered manager told us each incident had been reported to the persons social worker who then investigated and resolved them. The social worker's manager at the local authority confirmed this to us and said this was the agreement they had with the registered manager. However, the registered manager had not notified us of these concerns or completed a safeguarding referral form. We informed the registered manager the importance for services to report all safeguarding concerns through the correct channels so everyone can be assured the concern is investigated thoroughly and in line with the agreed South Yorkshire safeguarding protocols. The registered manager assured us she would complete the correct notifications for all incidents.

The registered provider had a safeguarding and whistle blowing policy, which staff were aware of. Whistleblowing is one way in which a worker can report concerns, by telling their manager or someone they

trust. Staff spoken with were aware of this policy and said they were confident to use this if necessary.

The registered manager kept a record of all accidents and incidents. We saw when there had been an accident or incident an investigation was completed to look at why this happened. Actions, such as staff retraining had been completed which helped prevent further reoccurrence of the accident or incident.

People were confident in the support they received with their medicines. At the time of the inspection staff were supporting two people with their medicines. We looked at the records kept of medicine administration and found these were fully completed. All staff had completed training in medicine administration. One member of staff described the process for the medicines being ordered, delivered, and stored in the person's home, as well as any surplus (such as PRN paracetamol) being returned to the pharmacy. Staff told us managers had observed them administering medicines during spot checks.

We looked at the recruitment files for four staff and found checks had been completed prior to people being employed. For example, employment history had been recorded and Disclosure and Barring Service Checks (DBS) were completed. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, by disclosing information about any previous convictions a person may have.

At the time of the inspection the service was providing care and support to four people. Two people were taken out for between four and 12 hours each week to provide respite for their family. The other two people had 24 hours a day, seven days a week care provided by a rotating 12 care workers. This meant there were enough staff to ensure care and support was provided to people at the agreed times and frequency. People told us the staff were varying ages, different gender and from diverse backgrounds and they liked this because it meant they each had unique skills. For example, one person was very interested in 'Bollywood' and they told us one care worker had the same interest and could talk to them about Bollywood films, music and actors.

Staff told us personal protective equipment (PPE) was provided and used when it was appropriate to do so. For example, staff said they wore gloves and aprons when providing care and preparing meals. We saw confirmation of this whilst we were carrying out home visits.

Requires Improvement

Is the service effective?

Our findings

For the two people receiving care over 24 hours and seven days per week, relatives and those who knew the person well were involved in developing care plans. This meant care plans reflected people's beliefs, the outcomes that mattered to people and ensured their preferences were met. Care plans were written so they promoted people's human rights.

Staff spoke about people with respect and without judgement. This meant people were protected from discrimination on the grounds of their gender, race, sexuality, disability or age. However, for the two people receiving respite care the same detail was not recorded in a care plan and a care plan was not available in their home. Staff were using the information provided to them from the initial assessment which was up to date and useful but did not cover all aspects of their care and support. We discussed this with the registered manager who confirmed care plans had been put in place following the inspection.

The registered manager and staff worked collaboratively with relatives and healthcare professionals to ensure people's health care needs were monitored and met. Staff knew people well and were aware of when they were required to escalate any concerns to people's families and/or the registered manager. Where health professionals such as physiotherapists, nurses and speech and language therapists had assessed the person their advice and instructions were incorporated into the care plan. This ensured care was delivered in a way that reflected current good practice and met individual needs.

Where people were supported by care staff to eat and drink they were involved in decisions about this. This meant any dietary, cultural or religious needs were respected. People were encouraged to have a balanced diet that supported their health and well-being whilst respecting their rights to make unwise decisions. There were systems in place to ensure staff were aware of safe swallow plans drawn up by a speech therapist, for example, where people needed their drinks thickened, to help them swallow safely.

When we spoke with staff about the support they received from the registered manager their opinions differed. Although some staff felt very well supported most staff spoken with said they felt support and communication with the registered manager had deteriorated over the recent months. They said they saw a lot of the registered manager, whilst out providing care but did not have one to one supervisions. One staff said, "The appreciation doesn't seem to be there, it sometimes feels like it's never good enough." Another staff told us, "The support just doesn't seem to be the same, I don't know why. We've tried to get a staff meeting but it was cancelled." However, one member of staff said, "I have respect for the registered manager. We get on well and I can go to her if I have any concerns."

We spoke to the registered manager about this. She told us she was surprised by how staff were feeling and said she would arrange to meet with them to look into their concerns. The registered manager also acknowledged that staff were not being provided with formal, planned one to one supervision and said this would be arranged as a matter of urgency.

We saw there was a system in place for staff to receive an annual appraisal of their role and to discuss their

professional development. Staff confirmed to us they had completed their appraisal and we saw evidence of this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Where someone is living in their own home, applications must be made to the Court of Protection.

We found people's mental capacity had been assessed and staff were aware of how this impacted on people who used the service. Staff were knowledgeable on Deprivation of Liberty Safeguards (DoLS) and decisions being made in people's best interest if they lacked capacity to make a specific decision or choice. Staff could describe how they promoted choice and responded sensitively and appropriately to people not wanting care. One member of staff told us, "I use gentle reasoning techniques but I respect people and report if they refuse care."

People told us staff had the skills they needed to care for them appropriately. Staff felt confident they had the skills they needed and felt able to ask for refreshers whenever they needed to. One member of staff told us, "I've had classroom training and completed e-learning." Another said, "Training is good and has included such as moving and handling, safeguarding, first aid, medication and food safety."

We saw there was a system in place to monitor staff training. This highlighted when staff were due to update each subject. This meant the registered manager could plan or prompt staff to complete as necessary. The PIR told us all staff had achieved a relevant NVQ or Diploma in Health and Social Care at Level 2 or above.

The induction process covered the knowledge requirements of the Care Certificate. This certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. Staff then developed their skills through shadowing a more experienced care worker until they felt confident enough to work alone.

Good

Is the service caring?

Our findings

People told us they liked the staff and made comments such as, "They are all very nice and kind" and "I'm perfectly happy. They're all nice but I have my favourites." People confirmed they always received care from staff who had been introduced to them and said staff who supported them were familiar and consistent.

Whilst out on visits one person was eager for us to see a video diary they had started, which was recommended by their social worker. This was not done daily but offered periodically to record anything important the person wanted to remember, show others or just reflect on. We saw staff had supported the person to record themselves singing and imitating local accents, which they were clearly very proud of.

One healthcare professional told us, "My clients absolutely love all the staff at the service. They are always very happy with the care they receive and are most certainly thriving in their care. I have no concerns what so ever about the level of care provided and I know all the staff have people's best interests at heart."

Kindness, compassion and an enthusiasm to provide a caring service were evident across the staff team who described people in very positive ways. Staff spoken with prior to the inspection told us we would really enjoy our visits to people who used the service because, "They're so lovely, it's a pleasure to care for them."

Whilst attentive the staff also respected people's space and autonomy within their homes. We observed a care worker interact with people. They spoke with people with respect, calling them by their chosen name and by providing the level of care and support the person wanted in a calm and relaxed, but professional way. This approach enabled people to make as many decisions as possible about how they wanted to receive their day to day care.

Staff told us they were not rushed and described the parts of daily life people could undertake themselves. Staff were passionate about the importance of promoting dignity in all situations. One care worker told us: "We really help people to retain as much independence as possible and this has resulted in people making more and more decisions for themselves and helps them maintain their dignity. This is really great for us and them."

People were encouraged to do as much for themselves as possible and retain their daily living skills. Staff had respected people's wishes if they had chosen to make an unwise decision such as refusing care. They had reported these decisions to the registered manager who monitored the situation and sought additional advice from healthcare professionals if required.

The values of the registered manager were embedded into the staff practice. Staff spoke with care about their colleagues. They understood the demands of the care staff's role and were supportive of each other and valued the work they did.

People agreed in advance how staff should access their home. This included whether they wanted staff to knock at their door and be invited in or to enter their home using a key safe. This was documented in

people's support plans.

Good

Is the service responsive?

Our findings

People who used the service said the managers and staff at the service were responsive to their needs and dealt with any concerns they had in a timely manner. Whilst out on visits we observed staff acting responsively to people's requests. For example, one person was asking to call their relative and the care worker organised this promptly as they were aware the person would become very anxious if this was not done straight away.

Staff spoken with were well informed about the people they provided care and support to. They were aware of their likes and dislikes, preferences and interests, as well as their health needs which enabled them to provide a personalised service. Staff told us if they noticed any changes in a person they supported; they would contact the managers at the office to seek their advice and support. They said managers would then contact people who were involved in the persons care, for example, the GP, district nurse and family members to decide what would be best for the person.

People received care from staff who focused on their care needs and preferences. People were initially assessed by the registered manager to ensure the service could meet their individual personal care needs and their preferred visit times. They discussed and assessed their physical and mental well-being and gained an initial understanding of the level of support they required and their personal and health backgrounds. This information informed the person's care plan. Where possible people, their relatives or advocates and other healthcare professionals had been involved in the care planning and the assessment of their health, well-being and support needs.

We found the care plans were mainly person centred and provided staff with details about people's preferred routines of care. However, as previously referred to in this report risk assessments were not included in the care plans and for two people a full and complete copy of their care plan was not in their home. This was rectified immediately following the inspection.

At each visit staff completed record sheets detailing the date of the visit, arrival time, finish time, tasks and services carried out, concerns or changes in health or behaviour and action taken in response to this. Staff then signed the record. Record sheets we looked at were fully completed by staff and confirmed staff were providing care and support throughout the agreed timeframe.

People and staff told us they had been provided with telephone numbers for A1 Medical & General and could ring the office if they needed to, both during office hours and out of hours. People and staff said if they contacted the office, the office staff sorted things out straight away.

We saw many examples of people being supported by staff to avoid social isolation. Staff encouraged and supported people to continue to follow their hobbies and interests. For example, we spoke with two people who told us staff were supporting them to go on a holiday. They were both really excited about this. People also told us staff supported them to go out shopping, go to the cinema and attend get togethers for activities which they had an interest in for example, a singing group.

At the time of our inspection, no one being supported by A1 Medical & General was living at the final stages of their life. The registered manager explained that if they were asked to support people who required end life care staff would be suitably trained in this specialist area.

We looked at the registered providers complaints policy and procedure. It included information about how and who people could complain to and explained how complaints would be investigated and how feedback would be provided to the person. There was also advice about other organisations people could approach if they chose to take their complaint externally, for example the local government ombudsman and the local authority. Information about complaints was also in the service user guide that each person was given a copy of when they started to use the service. At the time of the inspection the service had not received any complaints. One healthcare professional told us, "I have no complaints about this service. They are good at what they do. If any concerns are raised they deal with them promptly and fairly.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the service had a manager in post who was registered with the Care Quality Commission, in accordance with the requirements of their registration. The registered manager was also the registered provider and was supported by another senior manager and office staff who shared the responsibility for the day to day running of the service.

The registered manager was knowledgeable about people who used the service. She knew people who used the service and could talk in detail about their care and support needs. The registered manager told us she audited all areas of the service, which included accidents and incidents, complaints, safeguarding, staffing, health and safety and medicines. However, written evidence that audits were completed was not always recorded. Whilst the registered manager had good insight into the service being delivered and was acting to improve the quality of the service, they had not always ensured that shortfalls in relation to recordkeeping was addressed. For example, ensuring written risk assessments and care plans were in people's homes.

We saw accident, incidents and safeguarding files contained all relevant information for individual incidents or concerns. However, there were no systems in place to monitor these areas to identify any themes or trends. Therefore, there were limited records to show what action the service had taken to reduce the risk of reoccurrence of such events. This meant there was a lack of oversight and good governance.

People who used the service and their relatives were regularly asked for feedback over the phone, during visits and through questionnaires. Staff had also been asked to complete a survey to give their views of the service. However, other people who had an interest in the service, for example, healthcare professionals, were not included in the quality assurance process. Also, people's responses had not been collated into a report showing what action the registered manager was to take in response to listening to people's views.

From our discussions with staff it was evident they did not all feel they were well supported. Systems in place to ensure staff were fully supported in their roles were not being carried out as detailed in the registered providers policies and procedures. For example, the staff supervision policy stated supervisions would be carried out on a two-monthly basis as a minimum. Information from the staff and records showed staff were not being provided with one to one supervision.

Staff also told us staff meetings were not being held regularly. We saw minutes from the last staff meeting that was held in April 2018. The registered manager told us they had arranged a meeting in July 2018 but staff had not turned up. The registered manager said she would arrange a staff meeting as a matter of urgency so that staff could talk to her about their comments to us and look at ways to ensure they felt fully supported.

Throughout the inspection the registered manager and management team were honest and open with us. They acknowledged the shortfalls identified in this inspection in the area of the business which was registered to provide personal care. They were eager to put processes in place to ensure people receiving personal care were safe and protected from harm.

The registered manager and management team was responsive to the input of other professionals. We saw they were liaising with other professionals and responded appropriately to concerns identified during our inspection. One professional told us: "The manager and deputy manager have listened to suggestions we have made and are very responsive to any concerns. They listen which is very important and swiftly take action when needed."

We saw policies and procedures in place which covered all aspects of the service. We looked at a sample of the policies and found they were regularly revised to keep them up to date. Staff told us policies and procedures were available for them to read and they were expected to read them as part of their training programme.