A & K Home Care Services LTD

A & K Home Care Services Ltd

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected A & K Home Care Services on 26 January 2017. The inspection visit was announced two days before we visited so we could be sure the manager was available to speak with us. This was the first time the service had been inspected.

A & K Home Care is registered to provide personal care and support to people living in their own homes. There were 29 people using the service at the time of our inspection visit. The service offered support to people dependant on their specific needs, some people received one call a day; other people received four calls each day.

A requirement of the provider's registration is that they have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. There was a registered manager in post at the time of our inspection visit who was also the provider. We refer to the registered manager as the manager in the body of this report.

Staff received training in safeguarding adults and understood the correct procedure to follow if they had any concerns about people's safety. All necessary checks had been completed before new staff started work to make sure, as far as possible, they were safe to work with people. The manager and staff identified risks to people who used the service and took action to manage identified risks and keep people safe.

There were enough staff employed at the service to care for people safely and effectively. People were supported by a staff team that knew them well. New staff completed an induction programme when they were employed to ensure they had the skills they needed to support people effectively. Staff received refresher training and had their practice observed to ensure they had the necessary skills to support people. Staff had regular meetings with their manager in which their performance and development was discussed and development plans were agreed.

People's care was planned with them, and with the support of their relatives and staff at A & K Home Care. This helped to ensure care matched people's individual needs, abilities and wishes.

The manager and staff understood their responsibilities under the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure people were looked after in a way that did not inappropriately restrict their choices and freedom.

Staff were described as being caring and kind. Staff respected people's decisions to make their own choices and supported people to maintain their independence.

People were supported with their health needs and had access to a range of healthcare professionals where

a need had been identified. There were systems in place to administer medicines safely. People were supported to prepare food that took account of their preferences and nutritional needs.

People who used the service and their relatives, were encouraged to share their views about how the service was run. People knew how to make a complaint if they needed to. Feedback gathered by the provider from people and their relatives was used to drive forward improvements.

Quality assurance procedures were in place to ensure the quality of the service was maintained. These included regular checks of people's care plans, medicines administration and staff's practice. However, some audit checks had not been completed recently, due to a vacancy for a deputy manager. The vacancy was being recruited to at the time of our inspection visit.

Accidents and incidents were monitored and investigated, and actions were taken to minimise the risks of a re-occurrence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe with staff in their own homes. People received support from staff who understood the risks relating to people's care and supported people safely. Staff understood their responsibility to keep people safe and to report any suspected abuse. There were enough staff to provide the support people required. People received their medicines as prescribed and there was a thorough staff recruitment process to ensure staff were of a suitable character to work with people.

Is the service effective?

Good

The service was effective.

Staff completed training and were supervised to ensure they had the right skills and knowledge to support people effectively. The manager understood the principles of the Mental Capacity Act 2005 and staff respected decisions people made about their care. People who required support with their nutritional needs received support to prepare food and drink and people were supported to access healthcare services.

Is the service caring?

Good

The service was caring.

People were supported by staff who they considered kind and who respected people's privacy and promoted their independence. People received care and support from consistent staff that understood their individual needs.

Is the service responsive?

Good

The service was responsive.

People and their relatives were fully involved in decisions about their care. People's care needs were assessed and people received a service that was based on their personal preferences. Staff understood people's individual needs and were kept up to date about changes in people's care. People knew how to make

a complaint and the provider acted in response to improve their services.

Is the service well-led?

Good

The service was well-led.

The manager was the provider of the service; the manager conducted regular checks on the quality of service, however, some checks had been delayed due to a vacancy at deputy manager level. The manager was recruiting to the vacancy, and was developing further quality assurance tools at the time of our visit. People and staff told us the manager was accessible and staff felt supported to do their work.

A & K Home Care Services 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 was 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 visit took place on 26 January 2017. The inspection visit was announced two days before we visited so we could be sure the manager was available to speak with us. The inspection was conducted by one inspector.

We reviewed the information we held about the service. We looked at information received from statutory notifications the provider had sent to us and information from the commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are representatives from the local authority who find appropriate care and support services which are paid for by the local authority.

We spoke with the registered manager and received feedback from a care co-ordinator and one member of care staff. We spoke with one person who used the service. Because some people were unable to talk with us due to their complex care needs, we asked their relatives to provide us with feedback on the care their relation received. We spoke with five people's relatives.

We reviewed three people's care plans to see how their care and support was planned and delivered. We checked whether staff had been recruited safely and were trained to deliver the care and support people required. We looked at other records related to people's care and how the service operated including the service's quality assurance audits and records of complaints.

Good

Is the service safe?

Our findings

Some of the people who used the service had difficulty in communicating verbally, so it was difficult to ask specific questions about whether they felt safe around staff. People's relatives told us they felt their family member was safe. One relative said, "Yes, the carers are good." Another person said, "[Name] is safe enough with the staff."

People were supported by staff who understood their needs and knew how to protect people from the risk of abuse. Staff attended safeguarding training regularly. This training included information on how staff could raise issues with the provider and other agencies if they were concerned about the risk of abuse. Staff told us the training assisted them in identifying different types of abuse and they would not hesitate to inform the manager if they had any concerns about anyone's safety. The provider had a procedure in place to notify us when they made referrals to the local authority safeguarding team, where an investigation was required. The procedure required them to keep us informed of the outcome of the referral and any actions they had taken that ensured people were protected.

The provider's recruitment process ensured risks to people's safety were minimised. The provider's recruitment procedures ensured staff were of a suitable character to work with people in their own homes. Staff told us and records confirmed, they had their Disclosure and Barring Service (DBS) checks and references in place before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services. The provider also rechecked staff's DBS every three years during their employment, to ensure they continued to be of a suitable character.

The provider had contingency plans for managing unforeseen circumstances which might impact on the delivery of the service. For example, emergencies, such as the manager's unexpected absence was planned for.

There was a procedure to identify and manage risks associated with people's care. People had an assessment of their care needs completed at the start of the service that identified any potential risks to providing their care and support. Risk assessments were up to date, were reviewed regularly and included instructions for staff on how risks to people could be minimised or managed. For example, where people required two members of staff to assist them to move safely, risk assessments and care plans clearly documented the number of staff needed, and any equipment that should be used such as 'slide sheets'. Staff confirmed they referred to the information in risk assessments and care records to manage such risks to people's wellbeing.

We looked at how medicines were managed. Most people administered their own medicines or their relatives helped them with this. Only four people who used the service received support from staff to take their medicines.

Staff told us they administered medicines to people as prescribed. They received training in the effective

administration of medicines. This included regular checks by the manager on staff's competency to give medicines safely. Care staff recorded in people's records that medicines had been given and signed a medicine administration record (MAR) sheet to confirm this.

We looked at the MAR records for three people. We found a gap (for a single date) on two people's MAR sheets for the month of December. This is where staff had not recorded that the person's medicine had been given to them. We also found people who were prescribed cream as a topical medicine for their skin, did not have these recorded on their MAR sheet as being given by staff. We were however satisfied that people had received their medicines.

We brought this to the attention of the manager during our inspection visit, as these omissions had not been picked up during a routine monthly audit of the MAR. The manager explained that audits of the MAR charts had been put on hold, as they had a vacancy for a deputy manager so some managerial tasks had been delayed. The manager told us creams would be recorded, and MARs would be checked by senior care staff each week to identify any gaps, before they were returned to the office for monthly auditing. They confirmed this system had been implemented following our inspection visit.

People we spoke with gave us mixed feedback about whether there were enough staff to always meet their needs. One person's relative told us they would prefer an earlier call to their relation, but one was not available at the time they wished. They added; this was due to a lack of communication with commissioners of the service when they started using A & K Home Care, as the service wasn't informed about the time of the call they preferred when they took on their relation's care. They added, "They have tried to find us an earlier time, but this still isn't as early as we would like."

Most people told us there were enough staff to meet their needs as staff attended their scheduled calls, and usually arrived on time. One person's relative said, "The carer that came today is really good. They come on time and do a good job. We had a missed call once, but it's got better. We like the carer we have at the moment."

The manager explained that during the last twelve months A & K Home Care staff had missed two calls due to a mistake on their rotas. They had also logged a number of late calls. Since then more staff had been recruited, and a new electronic system had been put in place to schedule the rotas. The manager said, "This new system should ensure we do not miss any future calls."

Staff agreed there were now enough staff to care for people safely and effectively. The care co-ordinator commented, "We all work as a team and have good communication to ensure calls are on time." The manager confirmed they did not use agency or temporary staff. Although the service had a full complement of staff, they were recruiting at the time of our inspection to ensure there were enough staff to cover unforeseen staff absences, and to allow more flexibility in the staff team.

The manager explained how they monitored when staff arrived, and when staff left their scheduled calls to ensure staff arrived and left at the right time, and people received all the allocated time for their call. The manager said, "At the moment we check each member of staff's time sheets to ensure they are delivering the right number of minutes to each person. We are also just introducing a new call monitoring system. Staff will log in and out of each scheduled call using a mobile telephone. This means we will know where staff are and how long they stay with each person. We also conduct spot checks on staff." The new system would be monitored by the care co-ordinators to check that staff arrived and left each call within the agreed time.

One person's relative told us, "Staff are supposed to ring and let us know if they are going to be late, but they

don't always do this." The manager told us, "Care staff are asked to call people if they are running late, or report this to the office, so the person can be called." They explained each person was given a time for their call, care staff should arrive within 30 minutes either side of the agreed time. This arrangement maintained flexibility to allow for unavoidable delays, sometimes due to traffic, weather conditions, or an emergency at the previous call.

Good

Is the service effective?

Our findings

People told us staff had the skills they needed to support them or their relation effectively with their care needs. One person's relative said, "The care is good, staff know what to do."

Staff told us they had an induction which involved meeting the people they were to support as well as attending a recognised induction programme, to ensure they had the skills they needed. Staff told us their induction included working alongside an experienced member of staff, and training courses tailored to meet the needs of people they supported. For example, staff received training in how to move people safely if they had limited mobility. The induction training was based on the 'Skills for Care' standards. Skills for Care are an organisation that sets standards for care workers in England. The induction provided staff with a 'Care Certificate', which is a recognised qualification.

Staff told us in addition to completing the induction programme; they had a probationary period and were regularly assessed to check they had the right skills and attitudes required to support people. The manager explained probationary periods were continued until staff were competent in their role, and staff's competency was checked regularly (by observing their practice in a person's home) to ensure they continued to have the right skills and attitudes.

Records confirmed care staff received regular training to keep their skills up to date and provide effective care to people. This included training in supporting people with medicine administration and safeguarding adults. Staff also had specialist training in certain areas, depending on the needs of each person they supported. For example, some staff received training in dementia if the person they supported had the condition. One member of staff told us about a recognised qualification they were being supported to take saying, "I have been offered the opportunity to achieve my level 5 in Health and Social care which I am very much looking forward to."

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

The manager understood their responsibility under the MCA. They told us there was no one using the service at the time of our inspection that lacked the capacity to make all of their own decisions about how they lived their daily lives. We were told some people lacked capacity to make certain complex decisions, for example how they managed their finances. These people had somebody who could support them to make these decisions in their best interest, for example a relative or advocate. Where people lacked the capacity to make complex decisions 'best interests' decisions were made following a mental capacity assessment, in

conjunction with health professionals and people's representatives.

All staff had completed training in the MCA and knew they should assume people had the capacity to make their own decisions, unless it was established they could not. Staff knew they should seek people's consent before providing care and support. Staff said the people they supported could generally make everyday decisions for themselves. We asked people if staff asked for their consent before they provided care, they said they did. One member of care staff said, "I always listen to the person to find out about their preferences. Everyone has the right to make their own life choices. If a person has limited capacity, decisions can be made in their best interests. The person would also be provided with an independent advocate who will support them to make decisions in certain situations."

The manager reviewed each person's care needs to assess whether people were being deprived of their liberties. Although no-one had a DoLS in place at the time of our inspection visit, the manager understood their responsibility to apply to the supervisory body for the authority to deprive people of their liberty, if their care included restrictions to their liberty, rights and choices.

People were offered support to prepare their meals, if this was part of their care package. People received support from staff to prepare and cook food according to their individual needs and preferences. One person's relative said, "They warm through [Name's] main meal for them. They are also supposed to make a sandwich for their tea later. Once they didn't put anything in the rolls we left, so I left the staff a note to make sure things were done as we liked in the future."

The provider worked in partnership with other health and social care professionals to support people's health. The manager confirmed people were referred to their doctor, district nursing team or other health professionals where a need had been identified. Records confirmed people had seen health professionals when there was a change in their health. Care records included a section to record when people were seen or attended visits with these professionals and any advice given was recorded for staff to follow.

Good

Is the service caring?

Our findings

All of the people we spoke with told us staff had a kind and caring attitude. A person's relative told us, "[Name] loves one of the staff, they are very friendly." Another relative said, "[Name] is happy with the staff, they enjoy their company."

People were cared for by a consistent team of staff, which helped them feel secure and maintained consistent care. Because staff usually supported the same people, they had a good understanding of people's care and support needs. The manager told us care staff were matched with the people they supported, for example, if staff were spending time chatting with people and keeping them company it was important to match people on personality as well as skills. The manager said, "Staff are always introduced to people before they support them. Obviously if people don't feel comfortable with a member of staff we would change them."

People were encouraged to maintain their independence. Plans were written down with the person and staff to identify which activities they needed help and encouragement with. In one person's care records we saw they were registered blind, and only needed support with specific tasks. It was clear from the records staff should always ask the person which tasks they wanted to do themselves, records said, 'The person can express their own wishes which should be respected by staff.'

People's relatives told us they frequently saw how staff cared for their relation when they visited them. One relative told us staff always treated their relation with respect and dignity. They said, "[Name] is always asked by staff what they want."

Relatives told us staff maintained their relation's privacy. One relative told us their relation was taken into another room or area when they were there, to ensure their privacy was maintained when staff supported them with their personal care. We saw this approach was confirmed in the records we reviewed. For example, one member of staff had reported an incident where a relative had refused to leave the room whilst they offered their spouse personal care. The member of staff had reported the issue to the office, who then contacted the relative and explained the person's right to privacy. A member of staff told us, "When I provide care to people I always make sure all dignity is kept at a high level by closing doors, curtains, and as long as the person is safe I will leave the room for privacy. I will also treat everyone as an individual and respect any routines they may have."

The manager explained the service was based around a small geographical area, staff also lived within the area and sometimes knew the people supported by A & K Home Care. Where this was the case, the manager made sure people were not supported with personal care by staff who knew them. They also asked staff to maintain confidentiality at all times about people in their care. The manager said, "It's important to stress it's a small community, staff need to keep information confidential at all times."

The provider ensured confidential information about people was not accessible to unauthorised individuals. Records were kept securely so that personal information about people was protected. People had a copy of

their care records in their home and could choose who had access to these.

Good

Is the service responsive?

Our findings

People's care and support was planned in partnership with them and people who were important to them, which enabled the provider to deliver person centred care. One relative commented, "We are always involved."

Care records were comprehensive and written so staff understood people's needs and abilities. For example, care plans included information on what each member of staff should do at each timed visit. Details included how staff should act to maintain the person's health, provide support to meet their needs, and respect their personal preferences. For example, records showed what food people enjoyed, a brief life history and what activities and hobbies they liked. Care records were regularly checked so people's records reflected their current support needs. This involved six monthly reviews, monthly checks of risks, and updates to care records where people's needs changed.

Daily care records detailing the care each person received were kept up to date by staff. These daily care records were used to handover information to the next member of staff coming in. This meant staff could respond to any changes to the person's health or care needs.

Where it was included in their care package people received support to pursue activities and hobbies they enjoyed. For example, one person received a visit from staff to keep them company. The staff member supported the person with interests and hobbies they enjoyed, for example, gardening and going out during good weather.
Information about how people could make a complaint was included in each person's service user guide, which they had in their home and received when they started using the service. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to.

There was a complaints log in place to identify any trends and patterns from complaints. However, no complaints had been received at the service in the last year. When complaints or concerns were received the manager told us they met with the complainant to resolve the issue to their satisfaction.

Good

Is the service well-led?

Our findings

The registered manager was also the provider and was part of a management team which included a director and care co-ordinator. The manager told us they had found their role demanding in the last six months, due to a staff vacancy at the deputy manager level. They explained they had found it difficult to delegate tasks to other team members, and were actively recruiting for the deputy manager role. A recently appointed care co-ordinator had begun to take on some tasks from the manager, and a second care co-ordinator was also being recruited to continue the sharing of administrative tasks at the agency's office. The care co-ordinator's role was to allocate staff to the staff rotas and to oversee staff training to ensure staff had the skills they needed.

The manager told us they promoted an open culture by encouraging staff to raise any issues of concern either through regular one to one meetings with their line manager, when they visited the office each week, or through regular team meetings. We saw team meetings were documented and staff were given an opportunity to raise any issues through any other business. We reviewed the minutes of a recent meeting. Staff had discussed the use of 'what's app' a system of communication that had been introduced at the service, to exchange information quickly to members of the staff group. The manager explained, "We use 'what's app' to communicate. Everyone has a phone, so we pass messages to each other through the system. It's really straightforward and we are informed of any issues straight away."

The manager wanted to gather feedback from staff about how improvements could be made at the service, and they were introducing a comments and suggestion box in the office, for staff to input their suggestions. They said, "We will also be placing an area within the main office to encourage people to nominate staff for achievements. A staff noticeboard is also being put up in the office to make it easier to exchange information."

As well as the manager operating an 'open door' policy where staff could call into the office at any time, there was also an 'on call' telephone number they could contact 24/7 to speak with a manager if they needed to. This provided staff with leadership advice whenever they needed it.

Staff told us they had regular meetings with their manager to make sure they understood their role. Regular checks on staff competency was discussed at these meetings, which made sure they put their learning and knowledge into practice. Meetings were held every two-three months, and staff had an annual appraisal to review their performance, discuss their objectives and any personal development requirements.

The manager completed regular checks of different aspects of the service. This was to highlight any issues in the quality of the care provided, and to drive forward improvements. For example, the provider's quality assurance system included asking people, visitors and relatives about their views of the service. A yearly quality assurance survey was undertaken asking people what they thought of their care. The responses to the most recent survey showed a high level of satisfaction. Comments included; "I am pleased with everyone who helps me", "It could not be any better" and, "The carers are pleasant and helpful." The manager explained, we also telephone each new client at the beginning of the service to ensure they are happy when

they first join us. In addition we always take the opportunity to ask people how things are going whenever we speak with them on the telephone or face to face."

The manager conducted regular monthly checks on care records, senior staff checked the arrival and leaving time of staff, and checked the daily records from each person's home to ensure care had been delivered in accordance with their care package. In addition 'spot checks' on staff were undertaken to ensure the service delivered quality care to people. The manager worked alongside staff regularly to shadow shifts, to ensure staff had the correct skills to support people.

The manager was developing a range of new tools to gather feedback about their service. Client surveys were to be sent out monthly to people who used the service for the next few months. This was to find out whether any further improvements were needed to the service, to meet people's needs. The manager intended to feedback the findings of surveys to staff to share any learning.

During our inspection we found two gaps on medicine administration records (MAR). We brought this to the attention of the manager as these omissions had not been picked up during a routine monthly written audit of the records. The manager explained that audits of the MAR charts had been delayed, as they did not have a deputy manager in post to complete the checks. A new care manager was being recruited at the time of our inspection visit to assist the registered manager with auditing procedures. The manager told us MARs would now be checked by senior care staff each week to pick up on any gaps, before they are returned to the office for monthly auditing. The care co-ordinator confirmed all medication errors would be recorded, reported and analysed to find patterns and trends. All such incidents would be used to improve safety and practice and to prevent re-occurrence.

The provider monitored accidents and incidents to make sure appropriate action was taken when necessary. Records showed, for example, accidents and incidents were analysed by the time and location of the incident, the possible causes and the actions taken. Actions taken as a result of analysis included referring issues to health professionals and sharing updated information with staff. People's care records were kept up to date with changes in people's care and health needs. In addition, risk assessments were regularly reviewed in response to people's changing needs and in response to investigations into incidents and any learning that arose from them.

Action was evident where the manager discovered areas for improvement. For example, a call monitoring system and new electronic system for the management of staff rotas had been introduced following some late and missed calls.