Profad Care Agency Limited

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## Inspection report

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Date of inspection visit:
18 December 2017

Date of publication:
29 January 2018

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Requires Improvement |
| 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 carried out this announced inspection on 18 December 2017. This was the first inspection since this provider registered with the Care Quality Commission in November 2016. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults.

Not everyone using Profad Care receives a 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 this inspection Profad Care was providing personal care to 39 people.

The service had a registered manager, who had been in post since October 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who used the service told us that this was a good agency, and that they felt treated with respect by their care workers. The provider had systems in place to assess people's needs and provide care in a way which met people's needs and preferences. Care plans included a high level of detail on how best to support people, including how to provide reassurance when people were anxious and upset. Records of care provided showed that people received care as planned. People's nutritional needs were clearly assessed and care workers demonstrated that they were meeting these.

The provider had systems in place to assess risks to people using the service and to ensure that people received their medicines safely. Staff were recruited in line with safer recruitment measures and assessed for their understanding of their roles as part of the interview process. Care workers had received a detailed induction in line with nationally recognised standards and were given the opportunity to shadow more experienced members of staff. Team meetings and newsletters were used to clearly outline manager's expectations of care workers, although these were not consistently carried out.

There were systems in place to ensure that people's views on their care were sought, including how they wanted care delivered and if they were satisfied with the care they were receiving. There were review processes in place, but as most people had not been receiving care for more than a few months it was too early to assess their effectiveness. Where there had been complaints and concerns the provider investigated these and was able to learn from these. Care worker's understanding of privacy and dignity were assessed during recruitment and spot checks, and there was information on care plans about how to promote people's independence.

People had consented to their care, and where they were unable to make a decision the provider was

meeting their responsibilities to assess people's capacity to make decisions and demonstrate that they were working in people's best interests.

Managers carried out spot checks on care workers to ensure their competence. We found that managers did not have robust systems in place to audit records such as medicines, finances and daily logs, which meant there was a risk that significant errors or omissions might be overlooked. We have made a recommendation about this.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not safe in all respects.

There was a lack of suitable audits of risk assessments, medicines records and records of finances to ensure that processes were always safely followed.

There were systems in place to address and manage risks, and safer recruitment processes to ensure staff were suitable for their roles. People's needs with regards to their medicines were assessed and suitable support was received.

### Is the service effective?

**Good**

The service was effective. Suitable assessments were carried out of people's care needs.

Care workers were assessed for skills and knowledge at recruitment and received an induction in line with nationally recognised standards. Care workers underwent shadowing, supervision and observations of competency.

There were measures in place to ensure people received support with eating and drinking.

The provider was obtaining consent to care and assessing people's capacity to make decisions in line with legislation.

### Is the service caring?

**Good**

The service was caring.

People told us they were treated with respect and kindness by care workers who protected their privacy. Staff received training in privacy and dignity and this was assessed during spot checks.

There was information on care plans on what could cause people to be unhappy and how care workers should address this. Care plans were clear on what people could do for themselves and how best to promote people's independence.

### Is the service responsive?

**Good**

The service was responsive.

People's care was planned in line with their needs and records of care showed that this was delivered accordingly.

There was a review process in place but it was too early to judge its effectiveness.

People knew how to make complaints and records showed that complaints were investigated and responded to in line with the provider's policy.

## Is the service well-led?

Good

The service was well led.

Managers had developed good frameworks to assess and plan people's care.

There were measures in place to monitor the quality of care people received and to ensure that care workers understood the expectations of them. Care workers told us they felt well supported by managers.

People were able to contact the office with any concerns they had.

# Profad Care Agency Limited

**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.

Why we inspected – This was a routine inspection carried out as the service had been registered with us and providing care for 12 months. Prior to the inspection we had not received any information of concern such as complaints, serious injuries or allegations of abuse about this service.

This inspection took place on 18 December and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. We visited the office location to see the registered manager and office staff; and to review care records and policies and procedures. The inspection was carried out by a single inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In carrying out this inspection we looked at records of care and support for six people, and records of medicines management for four people. We looked at records of recruitment, training and supervision for four care workers. We looked at policies and procedures, records of management communications, complaints and incidents and pre-employment checks.

During the inspection we spoke with the registered manager, the CEO of the company, a care co-ordinator, one care worker and the training co-ordinator. After the inspection, we made calls to three care workers, four people using the service and two relatives.

Requires Improvement

# Is the service safe?

## Our findings

Systems and processes were in place to manage risk and ensure people received safe care, however these were not checked in a way that ensured that issues could be detected promptly.

There were some minor discrepancies with the recording of medicines. For example, one person's medicines plan stated that their lactulose was to be given as needed, and this was recorded as such on medicines administration recording (MAR) charts. However, their visit plan stated that this was to be given daily, which may have resulted in this being given unnecessarily. One person's MAR chart stated that a medicine was to be given weekly in addition to medicines in a blister pack, but this was left blank as the weekly medicine was supplied within the blister pack. For another person, there was a medicine to be given weekly that was not recorded on the MAR chart on one occasion, however care workers had recorded within the daily logs of care that this had been taken.

We looked at records of medicines for four people and with these exceptions MAR charts had been correctly completed, however there was no evidence of auditing taking place, which meant there was risk that further discrepancies may not be noted. Similarly, logs of care provided were not routinely audited to ensure these were complete; of the four we checked only one had been checked to ensure that people's support was accurately documented.

We recommend the provider take advice from a reputable source on how to implement a system of audits to ensure people receive safe care.

We found that systems were in place to assess people's needs with regards to their medicines and record these, but medicines records were not routinely audited by managers which meant some discrepancies may not have been noted.

Care plans included clear information on the medicines people took and the support required, including whether this was to be prompted or administered. This included, for example, instructions to put a person's medicines in a cup and highlighted when a person was unable to hold a cup and put it in their mouths when required. For another person, a medicine was given weekly, and care workers were instructed when to give it, including to ensure the person remained sitting upright when taking it. There was a list of medicines in place for each person with dose, form and frequency, and when medicines were given as needed, there were instructions on when it should be given. Risk assessments had been carried out by senior staff and included whether the person was self-administering their medicines, checking that medicines were safely stored, time critical or whether the person was at risk of being confused.

There was evidence of some innovative practice. This included a person who lacked capacity to manage their medicines but was prompted to manage this independently with the help of a medicine dispensing machine; it was clearly documented how this was done and the support that care workers were required to give with this. Care workers had observations of competency carried out of administering medicines, which was recorded in routine spot checks or in some cases dedicated medicines observations.

The provider had systems in place to assess and manage risk. People had social and physical profiles in place, which highlighted risks in key areas such as mobility assistance, seizure, falling and using equipment. Where equipment such as hoists were in place, there was information on people's profiles about what equipment was used, including the make and serial number and when this was last serviced. We found that although the servicing date was in place, it was not always clear when the next service was required. For a new care package the provider did not have a record of when the hoist was last serviced, although they had been told this was within the last year. When we raised this with the provider they arranged for a service to be carried out and recorded promptly. Most packages of care had started within the last six months, and the provider had not yet carried out audits of files. Where people received support with shopping, the provider told us that these were recorded in books at people's houses which were referred to in care plans, however we found that these had not been returned to the office and therefore had not been audited to ensure that money was handled safely.

Senior staff carried out risk assessments of people's properties, including access arrangements, gas and fire safety, trip hazards and floor coverings. Home risk assessments included a room-by-room breakdown of possible hazards for the assessor to check and this was carried out in a suitable manner. There was information on people's files on the level of support they required in order to mobilise safely.

People who used the service told us that they felt safe when staff visited. One person told us, "Their main concern is that I am safe and have everything I need." People's understanding of safeguarding was assessed during recruitment and training was received by staff as part of their induction. Care workers discussed their responsibilities to safeguard people from abuse during supervisions and team meetings. Care workers we spoke with were able to describe signs that a person may be being abused and were clear about the need to report concerns. Staff told us they were confident their concerns would be taken seriously by managers. Care workers also received training on infection control as part of their inductions, which was also checked during spot checks of care. Everyone we spoke with told us that care workers used suitable equipment such as gloves and aprons when supporting them with care.

The provider had safer recruitment measures in place. This included obtaining a photograph, proof of address and identification and the right to work in the United Kingdom. Where a person had a particular class of visa, managers had researched this visa and checked that this meant the person was able to work in the UK legally. The provider had obtained evidence of satisfactory conduct in previous health and social care employment by taking references and obtaining a work history. The provider carried out checks with the Disclosure and Barring Service (DBS). The DBS provides information on people's backgrounds, including convictions, to help employers make safer recruitment decisions. We found that one person had started work four weeks before their Adults First check had been received in March 2017, which was at the time the provider was recruiting its first care workers. We reviewed a list of these checks and verified that in all other cases workers had received either a DBS check or an Adults First check before starting work.

The provider told us that they did not use Electronic Call Monitoring (ECM) systems, and that everyone using the service was able to make contact with the office independently or had family that were able to do so, and this was confirmed in the care records we reviewed. There was no evidence that calls had been missed.

Care workers told us they had enough time to travel to calls. Comments from care workers included "Sometimes it can be difficult because of traffic, but that's not the fault of the organisation" and "They try to allocate people closer to where they live, it's working for me." We checked the rotas of four care workers and saw that these were arranged in a way that meant staff could be expected to arrive on time. People who used the service told us they had no major concerns about punctuality. One person told us "More often than not they arrive on time, give or take ten minutes."

Where incidents and accidents had occurred there was evidence that the provider had taken action in a way which promoted learning from these. For example, an occupational therapist had raised concerns about the way staff were trained to use a hoist, the provider had investigated this and found no concerns, but had carried out spot checks of the staff members concerned. In another case a family member had highlighted that a staff member had not used a medicines dispensing machine correctly. The provider had carried out a medicines enquiry process in order to document the concerns raised, the provider's response and lessons learned. This included removing the care worker from the package and documenting a discussion with them, and to update the person's care plan to clearly indicate that care workers should not interfere with or open the machine, and we could see that this had taken place.

Good

# Is the service effective?

## Our findings

The provider had thorough systems in place to assess people's needs and plan their care. Nobody had been using the service for more than a year, and before receiving a service people had an assessment of their needs carried out by senior staff. This included a personal profile, information on the support people received, including informal support from friends and family and the person's living situation. Assessments included whether a person had a pendant to call for help, received 'Meals on Wheels' and who managed the person's finances if they were unable to do so. The provider assessed the level of support people required for personal care and dressing, including whether people were able to choose their own clothes and whether they could dress themselves. This assessment also extended to people's nutritional and continence needs. People's desired outcomes from their care were also recorded. We saw that information on assessments was used in order to inform their care plans.

The provider took steps to ensure that staff had the required knowledge and skills to carry out their roles. During the recruitment process, candidates were assessed for their understanding of their responsibilities in certain situations and their understanding of how to meet people's needs with regards to continence and pressure care. Candidates were required to take a test to demonstrate literacy and numeracy, such as understanding care plans, times and dates and recording. These had been scored by managers to ensure that people were competent in these areas.

Following an offer of employment, staff received an induction which involved completing a Care Certificate. The Care Certificate is a nationally recognised qualification which includes an identified set of standards that health and social care workers adhere to in their daily working life. New care workers undertook units including equality and diversity, communication, privacy and dignity, fluids and nutrition, awareness of mental health, dementia and learning disability, safeguarding adults, life support, health and safety, fire safety, moving and handling, food safety and medicines. People's knowledge in these areas were assessed and scored by a supervisor. The provider showed us their training room, which included beds, hoists and stands in order to demonstrate and practice safer moving and handling.

Care workers told us that they found this training helpful. Comments included "Yes, they do make sure that we are suitably trained", and "I recommend it to anyone because I was new. It does build you up a bit so you know what you're expected to go into."

At the time of the inspection none of the care workers had worked for the service for more than 12 months. The provider told us that staff would be expected to receive annual refresher training in medicines, moving and handling, safeguarding adults and food hygiene after 12 months. Records of induction showed that care workers received shadowing with a more experienced care worker on at least two occasions prior to starting work.

Care workers received formal supervision every three months, which was used to discuss with their line manager how they were finding the role, responsibilities, recording and person centred care. Managers used supervision in order to review people's skills and knowledge, such as going through certain scenarios to see

whether people knew how to respond to an emergency, and drew up a training plan at the end of supervision.

People who used the service told us that they received suitable help with eating and drinking. Comments included "They always check on me to see that I am eating well" and "They will cook if I want them to." People's care plans were clear on who was responsible for shopping, preparing food and heating it, and who would assist the person with eating if this was required. This included whether tasks were done by the person, a family member or a care worker. People's eating and drinking needs were assessed, including details of food that people did not eat for cultural or health reasons and any other dietary needs people had, and whether people had difficulty swallowing. Where a person's plan stated that they required pureed food or thickeners used for fluids, care workers had recorded in daily logs that these were being used. Where people needed support to eat their meals, there was dedicated time in people's visit plans. Care workers had recorded the foods people had eaten each day to show they received a varied diet and had recorded that they had left drinks out for people where this was required on the care plan.

There were measures in place to help people stay well. For each person, there was a medical history in place, including past and current diagnoses and how health conditions may affect them. People who used the service told us they were happy with the support they received to stay well. Comments included "Oh yes, they would say if they thought I needed the GP" and "[They] make me feel well."

The provider was working in line with the Mental Capacity Act 2005 (MCA). The Act 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. The provider had systems in place for assessing people's capacity and recording consent to care. When it was not clear whether people could make a particular decision for themselves, the provider carried out an assessment of capacity in line with the requirements of the Act, including whether a person was able to understand, retain and use information to make and communicate a decision. There was evidence of appropriate actions being taken, for example to understand a decision the provider had worked with a family member to translate, and in assessing a person's ability to retain information the person had told them a cricket score; the assessor had checked that this was correct.

Where people lacked capacity there was clear evidence of a best interests decision being made in line with the MCA for particular decisions, this included recording whether a person was likely to regain capacity, their current circumstances, previously stated wishes and the need to avoid discrimination. There was evidence that others, such as family members, had been consulted as part of this. We found that in two cases relatives had signed on behalf of a person who had capacity but was unable to sign for reasons of physical disability, but for one of these people there was evidence elsewhere of the person's consent to their care. The provider told us that they did not have a way of recording verbal consent to care and that this was something they intended to develop.

Good

# Is the service caring?

## Our findings

People we spoke with were positive about their care workers. Comments included "They are very good people", "We have a little giggle", and "It's the first agency that actually cares." Comments from family members included ""[My relative] interacts with them very well", and "Sometimes they play music for [my relative] and joke."

Most people we spoke with told us that they received support from consistent care workers, although two people said this was not always consistent, with comments including "Mainly yes, but they are swapped around during the holidays" and "I have got a little bit mixed around, they are trying to sort it out to be consistent." A care worker told us "I am really lucky, I've got regular clients and I know them very well."

Care plans included an assessment of people's emotional needs and mental wellbeing, including whether the person may get confused, anxious or suffer from low mood, and what care staff could do to alleviate this. There was evidence of people's views and wishes being included in the care planning process. Examples of this included one person's plan which stated "If I am feeling low I would like care staff to talk to me and console me" and another person's visit plan which included a time to check the person's purse and help them find this as they frequently misplaced this and became anxious as a result. Another person's plan highlighted that although they can become withdrawn in a particular situation, the person had never liked this, and so this was normal for them. In another plan it highlighted that the person did not like people to raise their voices, and stated "I simply won't respond."

There was information on plans about people's communication needs, such as the use of hearing aids, glasses and conditions that could affect this such as cataracts. Plans also included the things that a person could do for themselves and how care workers were to facilitate this, which contained considerable detail, including the person's preferred mode of address and a form of words the person would respond to in order to carry out a task for themselves. People told us they were happy with the level of independence promoted by care workers, with one person telling us, "That's what I want, and that's what they are doing for me" and a relative said "They help her, they encourage and talk to her."

People told us they were treated with dignity and respect. Comments included "Absolutely", "I would complain if they didn't", "They won't even have a cup of tea off me" and "They all have good manners and are courteous with the work they do."

Supervisors checked that people were treated with dignity and respect for their privacy during spot checks, and care workers undertook a unit on this during their induction. People who used the service told us that staff respected their dignity, with comments including "It's not nice having to give someone a wash but they are very discrete" and "They are very professional."

Good

# Is the service responsive?

## Our findings

There were measures in place to provide person centred care and care was delivered as planned.

People we spoke with told us they were aware of the contents of their care plans and were involved in this. Comments included "When we first started a lady went through it with me" and "[My relative] knows what the care plan is all about."

Care plans included an "About me" document, which included information on people's life stories, family and social networks, previous and current occupations, how people should be supported to express their cultural and religious needs and what people liked and disliked about their care. There was information on people's interests including hobbies and sporting interests, and how the person's social wellbeing should be maintained and how health needs had affected this. Personal hygiene plans were in place and indicated the level of assistance required and how to do this, including assistance to shower, getting in and out of the bath, how people preferred to have their hair washed and support required with oral hygiene.

We found that assessments were used to plan care in line with people's needs, and this was summarised into visit plans which outlined the exact support people required. These had been written in line with people's routines, including the days people liked to have showers or strip washes. There was information on how to meet people's preferences; for example one person's plan said "Give me two choices of clothes", and showed where they were kept and what clothes people liked. Care workers told us they found these documents useful. Comments included "I know which bits to look at, and when people are eating I sit and read them" and "They are very useful because you get to know what's happening."

People told us that these plans were followed. Comments included "They do everything they should", "They look at the book and see what they are meant to do" and "They always check if anything else needs doing."

Care workers had recorded the support people received to a high standard in people's care logs. These showed exactly what had been done, and included information on what people had eaten and their daily wellbeing. Logs of care showed that care was delivered as planned. This included meeting people's weekly and daily routines, such as supporting people to wash on certain days, and hoisting people from bed to their chair at particular times of day.

People were due to receive a review of their care within six weeks of the start day, although in some cases this was between four and 11 weeks. Reviews were used to assess whether people were happy with the time care workers arrived, the duration of care visits, tasks which were done, and whether staff appeared competent and followed infection control processes. Supervisors checked that people were happy with the communication they received from the office, whether there were any further issues to be discussed and whether people knew how to make a complaint. Most care packages were quite new and so it was too early to assess the effectiveness or regularity of the review process, but we saw evidence of one particular concern raised at a review being investigated and followed up further.

People told us they knew how to complain. One person told us "I have not had problems. If I did they would sort it out" and another person told us they had the telephone number of the office if they needed to complain. The provider had a suitable complaints policy and a process for recording and investigating complaints. We saw that when complaints had been received, the provider had carried out a suitable investigation and responded accordingly.

Good

# Is the service well-led?

## Our findings

People who used the service told us they either knew who the manager was or were given sufficient information that they knew where to find this. Comments were positive about the organisation in general, including "I would recommend Profad" and "I am happy with Profad."

Care workers told us they were happy with the support they received from managers, with comments including "Management is good" and "They'll call and make sure you're OK." All care workers had had at least one spot check carried out since they started working with the organisation, which included observations of how people interacted, how medicines were administered, whether care workers carried identification and wore the proper uniform. Managers also checked whether records and tasks were accurately recorded, and whether care workers had left the premises safely, including leaving out mobility aids and drinks if required. Care workers told us that managers checked they were providing high quality care. One care worker said "They shadow us and how we interact with them" and another told us "If something is not correct they will let you know and ask if you need any further support." A person using the service told us "They do unannounced inspections, they come in to check on them."

Managers had arranged clear systems for ensuring that people's needs were assessed and that care was planned accordingly. We saw that records of care were completed to a high standard, however only one log book we saw had been audited by managers; logs included a section for managers to sign to show they had read it but did not include a clear audit framework. We discussed this with the registered manager who told us they would develop this system accordingly. There were also clear systems in place to record what should be on a person's file, and these were completed accordingly. Most people had not been using the agency for longer than a few months, and a system of file audits was not yet in place. We found that there was not yet a robust system of audit in areas such as medicines and finances.

The provider recorded compliments about care staff and placed these on people's files, and good practice was recognised, for example through a 'carer of the month' scheme. At the time of our inspection the provider was holding a Christmas party for care workers, and had arranged two during the week so that people would be able to attend these.

There were suitable systems in place to obtain people's views on how care was being delivered. People using the service told us "They ring from time to time to see if everything is OK" and "[The manager] phones up quite often." These telephone monitoring conversations were recorded within a clear framework, and involved checking whether office staff were helpful, whether care workers were consistent, caring and polite and flexible enough to cater for emergencies. People were asked if they felt involved in their decisions.

The provider maintained an out of hours on call system, we saw that logs were kept of calls to this and the advice given by managers. A care worker told us "I have a good relationship with the office staff, they are easy to get hold of."

Managers also had measures in place to ensure that staff understood their expectations. For example, there

was a mannequin displayed in the office which was dressed in a uniform so as to clearly indicate the standards of dress expected. Most care workers had joined the organisation in March, and a team meeting had been held where managers outlined their expectations in key areas such as medicines, recording, contact with the office, use of the no entry procedure and out of hours management systems. Staff also discussed important areas such as whistleblowing, pressure sores and how to support people in hot weather. Another all staff meeting had taken place in May, but there had been no further meetings since this time. There was also a team meeting for office staff, which had taken place in April, May and September, and was used to brief co-ordinators on issues such as assessments, codes of conduct, any concerns raised from the local authority. There was also a quarterly newsletter for care workers which contained important information on key areas such as medicines, pressure care and no entry procedures.