Mushkil Aasaan Limited

Mushkil Aasaan

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 4 May 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. At our previous inspection on 9 September 2014 we found the provider was meeting the regulations we inspected.

Mushkil Aasaan is a domiciliary care service providing care and support to people in their own homes. At the time of the inspection there were approximately 120 people using the service.

There was a registered manager at the service. 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 and their relatives told us that care workers were caring and supported them in an appropriate manner. They told us they were offered choices and care workers asked for their consent before supporting them. They also said their privacy and dignity was respected. They told us they felt safe in the presence of care workers and they were competent when supporting them with hoisting.

We found there had been some incidents that required a formal CQC notification of which we were not notified.

The provider had robust recruitment checks in place which helped to ensure care workers were safe to work with people. These included checks on eligibility to work, written references and background checks including criminal record checks. Care workers completed an induction programme based on the Care Certificate over a period of six weeks. This helped to ensure they had the appropriate training to meet the needs of people using the service.

There were enough staff to meet people's needs. People and their relatives told us that care workers attended on time and if they were running late, they were always notified by the provider. This was backed up by a log of visits that was kept by the provider which showed a high level of visits that were attended on time.

Although care workers told us they felt supported, there was lack of formal one to one supervisions. This was not in line with the providers own supervision policy of four supervisions in a year.

The provider completed an assessment of people's support needs when they first started to use the service, this helped to ensure people received the care that they wanted. Risk assessments and care plans were written and a copy was kept in people's homes for care workers to refer to if needed.
The provider had recently changed the way care plans were written so that they were more person centred.

Not all of the care plans had been transferred to the new style.

Feedback was sought from people as part of the provider's quality assurance monitoring. We reviewed this and found that people had good things to say about the service they received. Other audits, such as unannounced spot checks took place. People told us that when they raised concerns, the provider listened and acted upon them. We reviewed complaints that had been received within the past year and saw that the provider documented and investigated these in a timely manner.

We found a breach of regulation in relation to notifications. You can see what action we have told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People said they felt safe in the presence of care workers. They told us they were competent in safe moving and handling techniques.

Care workers were able to identify the potential signs of abuse and who they could report concerns to.

Staff recruitment checks were thorough and there were enough care workers employed to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff received a thorough induction which helped them to support people in an effective manner.

Care workers were aware of the importance of asking for consent and offering people a choice when supporting them.

People's health and nutritional needs were met by the provider.

Is the service caring?

Good

The service was caring.

People and their relatives gave us examples when care workers had demonstrated a caring attitude.

People told us that care workers respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

An initial needs assessment took place when people first started to use the service. This was used to develop support plans for people.

People said the provider listened to them when they made a complaint and took action if needed.

Is the service well-led?

Requires Improvement

The service was not well-led in all aspects.

Although people told us they felt supported, the provider did not always carry out formal one to one supervisions in line with their own policy.

There were some incidents for which we did not receive a formal CQC notification.

Quality assurance checks in the form of unannounced spot checks and feedback surveys took place. These were positive about the service provided. However, they were different to the ones kept in the provider's policy book.

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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 checked 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 4 May 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection was carried out by one inspector and an expert by experience who carried out telephone interviews with people using the service and relatives after the inspection. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service. We asked the provider to complete a Provider Information Return (PIR) prior to our inspection. The PIR is a report that providers send to us giving information about the service, how they met people's needs and any improvements they are planning to make.

We spoke with nine people using the service, four relatives and staff members including the project manager, the registered manager, two homecare supervisors and six care workers. We looked at records including ten care records, training records, five staff records, complaints and audits.

After the inspection we contacted three social care professionals to gather their views and received responses from two of them.

Good

Is the service safe?

Our findings

People using the service and their relatives told us they felt safe when being supported by care workers and had no concerns. Some of the comments included, "She takes care of [my family member] and makes sure [my family member] doesn't fall down", "They come in every day and look after me", "They make sure I get in and out of the bath safely" and "I feel very safe around [the care worker]."

Staff members had received safeguarding training and were able to recognise potential signs of abuse. They knew who to contact if they had any concerns. One care worker said, "I complete the green (daily records) sheet, if there are any marks I record it and tell the office."

We saw that where concerns had been raised that constituted a safeguarding allegation, the provider had worked with the local authority to investigate these concerns and had followed the recommended guidelines to safeguard people from harm.

Relatives also told us that care workers used safe moving and handling techniques. They told us, "The [care worker] looks after his/her safety. He/she uses a hoist and I watch him/her as I am in the sitting room. The [Care worker] is very good with it, and is good at what he/she does." Another relative said, "They look after my [family member] and make sure he/she doesn't fall when she walks, they are good with transferring him/her into the shower. My [family member's] safety is my number one concern." Another said, "It is very safe especially with the way they use the hoist. The carer is well trained and helps [my family member] get out of the electric chair to go for a shower."

Care records included a moving and handling assessment and a falls risk assessment. The provider was in the midst of moving to a new style of care records, although the majority of people still had the previous records in place. These included risk assessments that looked at the external and internal environment, electrical appliances, general health, mobility, personal care and domestic tasks.

We saw some examples where risk assessments in relation to moving and handling had been developed by Occupational Therapist (OT). Although risks were assessed appropriately, we saw one example where a moving and handling risk assessment was scored between 9-14, a medium to high risk. According to the providers records this required a care plan to be developed. However, in the daily living mobility assessment it stated that there was no care plan required. We spoke with the registered manager and homecare supervisor about this who told us they were still getting used to the new format and would write one up as soon as possible.

All the people and their relatives that we spoke with did not raise any major concerns about timekeeping. They told us that they were always notified if the care workers were running late. They said, "She always comes on time", "If they are not going to come round they call", "They tell me when someone else will come instead", "A few times they have been late but they call to tell you where they are. They also call and tell you if someone is on holiday or not able to come that he/she will have a new carer", "Sometimes they have cancelled, it's not very often and they do call and keep me informed", "It happens now and then but

someone calls me and tells me what's going on" and "He/she will text me if he/she is running late and for not turning up, the [care worker] will tell me the week before."

Care workers told us they were given enough time to travel between calls and the provider took into account the distance between each visit which minimised the number of late visits. All care workers were issued with a unique PIN number and they clocked in and out at every visit. The registered manager told us they were satisfied and there were no issues with time keeping. This was because they had achieved a good level of compliance to show that care workers were arriving on time to the majority of their care calls.

Staff recruitment checks were robust. This helped to ensure people were supported by staff who were safe to work with them. All recruitment files were up to date. They included an interview checklist, observations during the interviews, such as care workers timeliness, personality, disposition and attitude. Files also included two references and a Disclosure Barring Service (DBS) check. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions

The home care supervisor who took responsibility for staff induction spoke with us about the recruitment of new care workers. They initially met with the new staff and examined all their relevant paperwork including right to work and interviewed them, If they were satisfied, they invited them to complete a formal application and applied for a DBS.

The people and relatives we spoke with told us they managed their own medicines, the care workers just gave them water or reminded them sometimes. The registered manager told us, "We just prompt for medicines, we don't administer." They said that the care workers completed their daily records if they prompted people to take their prescribed medicines. Care records indicated that where people were reminded to take their medicines, this was documented. However, care workers did not always write down which medicines they had prompted people to take.

Good

Is the service effective?

Our findings

Care workers told us they received training as part of their induction when they first started working at the service in a range of topics. They said this helped them to carry out their roles effectively. Some of their comments included, "The induction was good", "The last training I went on was end of life and dementia" and "I have done training on how to use the hoist." They also told us they shadowed more experienced care workers before they supported people independently. This helped them to gain a better understanding of providing personal care practically.

The home care supervisor with responsibility for induction and facilitating training went through a recruitment and induction of new staff. This included going over the provider's policies, care plans, the code of practice, and an overview of the expectations of the role. For example, how staff should complete timesheets and that they would be observed to assess their competencies when providing care in people's homes. There was a six week induction; we reviewed the induction programme which the care workers completed and found that it was suitable for preparing care workers for their role.

The training that was delivered to care workers was based on the Care Certificate, records indicated that eleven care workers had completed this recently. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. There are 15 different standards that are covered as part of the Care Certificate, these include duty of care, equality and diversity, working in a person centred way, communication, privacy and dignity, fluids and nutrition, awareness of mental health, dementia and learning disabilities, safeguarding, basic life support, health and safety and infection control.

Care workers completed workbooks which tested their knowledge and we saw some completed workbooks that had been completed and assessed by an external trainer.

Yearly appraisals took place but one to one supervisions were more informal, care workers usually turned up on Tuesdays to submit timesheets and management were available to speak with them. Care workers did tell us that there was an open door policy and they were able to visit and speak to care co-ordinators or registered manger throughout the week.

The Mental Capacity Act 2015 (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 application procedures for this in domiciliary care agencies are to be made to the Court of Protection.

People using the service told us they were consulted and involved in their care planning. They said "I have

seen my care plan I think. If I tell them something new they do update their files", "I believe I have a care plan", "I have a home care service record that will be filled in" and "I think I remember seeing one (a care plan) when I first came here. [The care worker] writes down what she does with me in a folder." Relatives told us they were also involved in this, "Yes I am her main carer so they all talk to me and discuss what's going on."

A copy of people's care plans were kept in the office and a second copy in their homes. The homecare supervisor told us they always sought people's consent to provide care when they first met them and recorded this in their care plans. In the majority of cases, their relatives were always present during these meetings, especially if people were not able to give valid consent and or had an underlying condition such as dementia which meant they may not be able to give consent.

Care workers said they also asked people for their consent before supporting them. One care worker said, "Always give them a choice, what they want to wear or eat", "I always ask them what they would like and we respect their decision."

People and their relatives did not raise any concerns with regards to the support they were given in relation to food and drink. They said, "Just breakfast if there is time. They don't cook or heat the food up but will give her a hot drink or a juice. They seem to be doing a good job", "He/she gives her food but unless it's something quick like a sandwich he/she doesn't cook for [my family member]", "[The care worker] will make me a slice of toast with marmalade in the morning. I also will have an orange and satsuma", "He/she will microwave something for to me. I pick whatever I feel like eating" and "Afterwards I get a nice meal like a slice of chicken, some yoghurt and a nice mug of tea. This is fantastic services."

Care workers told us people's preferences were recorded in their care plans but they always asked people what they would like for their meals. They told us sometimes they went out and did shopping for people, "I will go and buy basic food, such as bread and milk." They were familiar with people's dietary needs but said on most occasions, they simply had to prepare something from what was already available in people's homes or had to reheat food that had been prepared by them or their family members.

Care records contained details of health professionals that were involved in supporting people, in case they needed to contact them. They told us they would call the main office if they noticed changes in people's health or the emergency services if it was something that required more urgent attention. They completed a daily records log sheet in which they recorded any changes in people's health.

Good

Is the service caring?

Our findings

People and their relatives gave us examples which demonstrated the caring attitude of staff. One person said, "If I get short anything like bread or milk they will check to make sure it isn't in the fridge then go top up whatever I need as and when. It is an excellent service I give the buyer a list and she brings everything I want. Sometimes she may pick up something for me to try and if I like it he/she will buy it again. I trust them and they always come with receipts. I can't fault it." Another said, "He brings me my medicine from the pharmacy when he/she comes over as it's too far for me to travel." They also said that care workers were patient and nice to them, "Yes, she is wonderful. She never gets angry no matter what I do and she is always nice. Don't have a bad thing to say about her", "She is very nice. I like her" and "Yes very good, she is always polite and friendly."

Care workers promoted people's independence. They told us some people required more support than others but they always tried to encourage them to be as independent as possible. People told us, "Because I can't go upstairs he/she helps wash me downstairs. She brings me hot water from the kitchen and I can wash myself", "I like to go from Tooting Broadway to London Waterloo and there is a nice cafe there" and "I used to be very independent and they discussed with me how I could do it now. I do push myself to go downstairs. He helps me with whatever I want." A relative said, "On Thursday they try and take [my family member] out especially if the weather is nice to get some fresh air or go shopping."

We asked relatives if care workers respected their family member's choices, they told us "In one hour there is not a lot they can do but they do let her chose whenever she can." Another relative said, "He/She is quite intelligent and wants to be involved. They all talk and discuss things with [my family member]. They are very patient when doing it."

People said that their privacy and dignity was respected, one person said, "I do get a help with the bath and I feel comfortable with them." Care workers were given training on respecting people and what this meant in the context of delivering personal care. They were able to demonstrate how they did this such as asking people's permission before beginning personal care, keeping doors shut and only washing those areas that were necessary.

Care plans had been recently updated to make them more person centred and we saw evidence that the provider had started to document preferences when developing these new care plans. People's objectives and aims in relation to each support plan were also considered.

Good

Is the service responsive?

Our findings

The registered manager told us the majority of referrals came from the local authority, however some people paid for their care through direct payments where the funding authority paid them and they then paid the provider directly.

The provider received basic information about the care and support needs from the referring authority based on which they had to decide whether they could meet people's needs. The home care supervisor said, "We get background information from social services and we then decide if we can meet their needs." Following a decision, the home care supervisor visited people in their homes and carried out a needs assessment to gather more detailed information to be further developed into a care and support plan if all parties agreed.

We looked at some examples of the initial assessment that was completed. This covered the following areas, personal hygiene, mobility, breathing, eating and drinking, finances, continence needs, communication and sensory needs, mental health, medicines, end of life and physical health. Not all of these were assessed for every person, only those that were most relevant.

The registered manager told us they had recently moved to a new style of care plan to make them more person centred. This commenced in February 2016. Previously, the care records consisted of separate service user assessments, risk assessments, and support plans. The new style gave a more in-depth overview of people's care needs. Not all of the care records had been moved to this new style of care planning. We looked at some examples of the new style. They were laid out to be more person centred rather than task oriented and included records such as '10 things you should know about me.' They also included a social assessment, personal history, and overall aims/objectives with regard to meeting people's needs.

Care workers brought back daily records to the office every week, we saw some examples of some completed ones and saw that these were filled in correctly. They documented any changes to people's health, their support needs and which tasks were completed.

People were given information on how to raise a complaint when they first started to use the service in a 'service user guide.' This gave details of who to contact if they were not satisfied with the care and support they received.

People using the service told us if they had any concerns they would speak to staff about these. They told us that when they had previously made complaints, the provider had listened and acted upon their concerns and they were satisfied with the response of the provider.

Some of the comments were, "I haven't needed to make a complaint", "If I don't find a worker good I do tell the agency. They get me a new one right away", "[The registered manager] listens to everything I say", "I complained about not liking the other carer's. They changed them until I found one that I liked", "No we haven't had any major issues" and "No concerns, they were all dealt with straightaway. A person came

around and sat down with me and discussed what was happening and how we would go forward from here."

We looked at a record of complaints, since 30 April 2015 there had been 43 recorded complaints. We reviewed the complaints received over the past year. Each complaint was given a case number to allow for easier tracking. A complaints log was kept with details of the complainant, the person using the service if applicable, the nature of the complaint and any action taken. A separate complaints form had more detailed information about the complaint and included any other evidence such as statements from care workers.

Requires Improvement

Is the service well-led?

Our findings

We looked at some complaints and saw that there were at least two incidents which were of a safeguarding nature. Although the provider had contacted the local authority in response to these, no notifications had been received by the CQC in relation to these incidents.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 Care Quality Commission (Registration) Regulations 2009.

Care workers told us they felt well supported by their colleagues and the management team. One care worker said, "It's great, I'm very happy." Another said, "They (the office staff) are good, if we have any problems I can tell them." They said there was an open door policy which we saw during the inspection. Care workers were able to come into the office either to submit their timesheets, attend training or just to have an informal chat.

Despite this, there was a lack of formal supervision records in the files we saw. For two care worker's their last recorded one to one meeting with their supervisor was June 2014 and there were no records for these. We reviewed the provider's policy around staff supervision and we found that the provider was not following its own policy of four supervisions per year.

Care worker meetings were held, the dates of the previous ones were February 2016 and June 2015. Some of the areas looked at included CQC methodology, recording, health and safety and training. The registered manager told us it was sometimes difficult to persuade care workers to attend these so they tried to include a social element into these meetings to encourage participation.

Homecare supervisors carried out unannounced supervision observations or spot checks on care workers. We saw completed records of these, they looked at care workers communication skills, their general appearance, moving and handling technique, health and safety and the environment. Identified areas of improvement were noted along with the actions to complete. However we found that the makeup of these records differed from the spot checks template contained in the spot checks policy and procedure. We also found that there was no system for ensuring these were done on a regular, proactive basis as part of continuous quality assurance. They seemed to be done in response to any concerns raised and were more reactive in nature.

Incidents were logged appropriately, initially by care workers and then overseen by either the homecare supervisors or the registered manager. There was evidence that the provider acted appropriately in response to these to try and minimise future occurrences.

We reviewed a quality assurance survey for people using the survey in February 2016. The questions that were asked were based on the quality of care, whether people felt involved in planning, if their support plan needs were being met, if they felt listened to, respected and treated with dignity, if staff were friendly, and whether they were satisfied with respect to complaint handling. The feedback was positive with the majority

of respondents rating the service as good or excellent.

The provider had achieved accreditation in 'Investors in People.' This provides a best practice people management standard, offering accreditation to organisations that adhere to the Investors in People framework. The standard defines what it takes to lead, support and manage people well for sustainable results.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did notify the Commission without delay of some incidents related to abuse or allegation of abuse in relation to a service user; whilst services were being provided in the carrying on of a regulated activity. Regulation 18 (1) (2) (e)