Abicare Services Limited

Abicare Services Newbury

Inspection report

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Date of inspection visit: 21 July 2015
Date of publication: 28/08/2015

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

Overall summary

This inspection took place on 21 July 2015 and was announced. We gave the area manager 48 hours' notice as we needed to make sure someone would be in the office.

Abicare Services Newbury provides a service to people living in their own homes in Berkshire. At the time of this inspection they were providing a service to 31 people.

The service is required to have a registered manager. The registered manager has not managed the service since March 2015. The community team manager has been managing in her place, with the support of the area manager. The company is currently recruiting a new manager. The area manager has started the process to become registered with us in the interim. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 were protected from risks to their health and wellbeing and were protected from the risk of abuse. Staff received training to enable them to do their jobs safely and to a good standard.

People were treated with respect and their privacy and dignity was promoted. Staff were caring and responsive to the needs of the people they supported. Staff sought people's consent before working with them and encouraged and supported their independence.

People's health and well-being was assessed and measures put in place to ensure people's needs were met in an individualised way. Medicines were managed well and staff administering medicines were only allowed to do so after passing their training and being assessed as competent. Where included in their care package, people were supported to eat and drink enough.

People benefitted from receiving a service from staff who worked well together and felt management worked with them as a team.

People were not always provided with a service that was consistently delivered within the time slots agreed.

We have made a recommendation about the service exploring the reasons for late calls.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe. People were protected from abuse and supported to make their own choices. Risks were identified and managed effectively to protect people from avoidable harm.

People were protected because recruitment processes ensured staff employed were suitable to work with people who use the service.

Good

Is the service effective?
The service was effective. People were supported by staff who received induction and training suitable for their roles. People benefitted from staff who were supervised and supported in carrying out their work.

Staff promoted and encouraged people's rights to make their own decisions. The managers had a good understanding of their responsibilities under the Mental Capacity Act 2005. The area manager was aware of the requirements under the Deprivation of Liberty Safeguards, although not applicable to the people currently using the service.

Good

Is the service caring?
The service was caring. People benefitted from a staff team that was caring and respectful. People were treated with kindness and respect.

People's rights to privacy and dignity were respected and people were supported to be as independent as possible.

Good

Is the service responsive?
The service was responsive. People received care and support that was personalised to meet their individual needs.

The service was responsive in recognising and adapting to people's changing needs. People's right to confidentiality was protected and they were made aware of how to raise concerns.

Good

Is the service well-led?
The service was not always well led. People were not always provided with a service that was consistently delivered within the time slots agreed.

People benefitted from personal records that were up to date and reflected their needs and wishes. People benefitted from a staff team that worked well together and felt supported by their managers.

Requires Improvement

Abicare Services Newbury

Detailed findings

Background to this inspection

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

This inspection took place on 21 July 2015 and was announced. We gave the area manager 48 hours' notice because the location provides a domiciliary care service and we needed to make sure someone would be in the office. We were assisted on the day of our inspection by the service's area manager and community team manager.

The inspection was carried out by one 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.

Prior to the inspection we looked at all the information we had collected about the service. This included the previous inspection report and any notifications the service had sent us. A notification is information about important events which the service is required to tell us about by law.

As part of the inspection we spoke with eight people who use the service and three of their relatives. We spoke with the area manager, the community team manager and five of the 17 care staff. We received feedback from one local health professional. We contacted a local authority care manager and a health care professional but had not received feedback by the time of writing this report.

We looked at four people's care plans, five staff recruitment files and staff training information. We saw a number of documents relating to the management of the service. These included: the staff training matrix, staff supervision and appraisal log, quality assurance survey results from 2014 and the staff handbook.

Good

Is the service safe?

Our findings

People were protected from the risks of abuse. Staff had received safeguarding training and knew how to recognise the signs of abuse and what actions to take if they felt people were at risk. Details of who to contact with safeguarding concerns were also included in the staff handbook that all staff had been issued with. Staff were aware of the company's whistle blowing procedure and were confident to use it if the need arose. Staff were confident they would be taken seriously if they raised concerns with the management. People felt safe with the care workers and relatives were confident that their family members were safe with the staff. We saw from the service's safeguarding records that any allegations were taken seriously, reported to the local authority safeguarding team and also notified to the Care Quality Commission (CQC) as required. The records contained details of actions taken by the service as well as the outcomes of the investigation.

Risk assessments were carried out to identify any risks to people, or the staff, when providing the package of care. Identified risks were incorporated into the care plans and included guidance to staff on what to do to minimise any risk. For example, one risk assessment set out that the person could feel anxious in certain circumstances. The care plan detailed what staff needed to do to help the person reduce their level of anxiety and relax.

The service assessed the environment and premises for safety as part of the initial assessment. For example, slip and trip hazards and equipment to be used when providing the package of care. Other areas assessed for staff safety included the area local to the home of the person receiving the service, distance from parking to the person's home and other risks related to staff lone working and lone travelling. Care plans documented what actions needed to be taken by staff to reduce or remove risks to themselves. For example, moving and handling risk assessments set out measures staff should take to reduce risks when carrying out any moving and handling tasks.

People were protected as staff knew what to do if they saw any signs of potential health problems. For example, if they arrived at a call and the person was not well. Staff told us they would notify the office but would also call an ambulance if needed. Staff had received training in basic first aid.

The company provided staff with a handbook that they were required to read and adhere to while working for the service. The handbook included the company's expectations of staff and included protecting people's human rights. For example, policies on data protection, confidentiality, equality and diversity.

People were protected by appropriate recruitment processes. Staff files included the recruitment information required of the regulations. For example, proof of identity, evidence of conduct in previous employment and criminal record checks. There were some small gaps in employment that had not been explained in three of the files we saw. However, the area manager obtained the missing information from the staff following the inspection. The recruitment process ensured, as far as possible, that people were protected from staff being employed who were not suitable.

The majority of people, or their relatives, looked after their own medicines. In instances where the service supported people with medicines we saw this was set out in their care plans. The plans contained clear instructions to staff as to whether staff needed to prompt, assist or administer the medicines. The care plans also gave a definition of the three levels of assistance so staff were clear on what they needed to do. Only staff trained and assessed as competent were allowed to administer medicines. Staff had received medicines training to ensure the right people received the right drug and dosage at the right time. This was confirmed by the staff we spoke with and documented in their training records. We were not able to assess the most recent medicine records for people receiving support with their medicines, as they were kept in people's homes. However, medicines administration records seen had been completed by the staff administering the medicines.

Good

Is the service effective?

Our findings

People received effective care and support from staff who knew the people well and were well trained.

People were protected because staff had received training in topics related to their roles. Staff training records showed people had received induction training when first starting employment with the company. Induction training followed the Skills for Care common induction standards. We saw staff had received induction or update training in topics such as infection control, first aid, health and safety, food safety and moving and handling. Other training routinely provided included safeguarding adults at risk and the Mental Capacity Act 2005. Additional training had been provided and included medication theory and practice, pressure ulcer awareness and dementia awareness. Staff felt they had been provided with the training they needed to deliver good quality care and support to people using the service. Staff told us they had not been asked to do anything they were not confident to do. People felt the care workers were well trained and one person commented that the care staff: "know what they are doing and are very respectful."

The provider was aware of the new Care Certificate, which replaced the common induction standards in April 2015. The training department had developed and implemented a new induction training programme for all new staff which was based on the Care Certificate.

Staff had one to one meetings (supervision) with their manager to discuss their work and training requirements. Other supervision sessions included direct observational sessions. This is where a manager observes a member of staff working with a person using the service to ensure they are working to the provider's expectations. The staff handbook stated staff would have six supervision sessions each year. The log of supervision provided showed some people were overdue their supervision, which was confirmed by staff we spoke with. The community team manager was aware of this and arrangements were in place to schedule staff in for supervision in the near future. Annual appraisals of their work were completed with staff. We saw dates had been scheduled in July 2015 for the three that had been due in June. Other staff appraisals were up to date.

People's rights to make their own decisions, where possible, were protected. Care plans incorporated a section for people to sign to say they agreed with the content. Staff received training in the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The MCA also requires that any decisions made in line with the MCA, on behalf of a person who lacks capacity, are made in the person's best interests. Staff had a good understanding of the MCA and their responsibilities to ensure people's rights to make their own decisions were promoted.

The area manager was aware of the requirements of the Deprivation of Liberty Safeguards (DoLS). The DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty. The DoLS did not apply to the people currently using the service.

The service provided did not include responsibility for people's eating and drinking. But daily records included how much people had eaten where providing meals was part of the package of care and where there was concern. Where people were not eating well staff would highlight that to the office who would then pass on the concern to the person's relatives or care manager.

We asked staff what they would do if they arrived at a call and the person was not well. Staff told us they would call their manager and/or phone direct for an ambulance if one was needed. A health professional told us of a situation where one person had become very ill over a short period of time and was not eating. The health professional described how a staff member from the service had been the only person to identify the cause being a mouth ulcer. Once identified and treatment for the ulcer had been provided, the service had provided soft foods for the person to eat. The person had started eating almost immediately and their strength returned to normal. The health professional told us they had been very impressed with the staff member and their team. They felt the quality of communication had been very good and commented they had never had to chase the service for updates.

Good

Is the service caring?

Our findings

People were treated with care and kindness. One person told us: "I love the staff, they are very good to me." Another told us: "They often do additional things for me." A relative commented: "They are a caring mix of people, no-one hasn't been caring." A health professional confirmed they felt the service was successful in developing a positive, caring relationship with their client.

People were consulted and had signed their care plans to confirm their involvement and agreement with the contents. Staff knew the people who use the service and how they liked things done. Staff explained they always asked people for permission before providing any care or support. They were aware of the content of the care plans and their answers demonstrated they had read them. Staff felt they were allocated enough time to provide the care required in the way the person wanted. People confirmed staff stayed the correct amount of time and that staff did not rush them.

People told us staff respected their privacy and dignity. One person told us: "They are very caring, they make me laugh, they know what they are doing and are very respectful." Staff described how they always made sure, when assisting people to wash and dress, that they were kept covered as much as possible. Staff told us that personal care was carried out behind closed doors, even though people were in their own homes.

People were supported to be as independent as possible. The care plans gave details of things people could do for themselves and where they needed support. Staff told us they encouraged people to do the things they could and the care plans set out instructions to staff in how to provide care in a way that maintained the person's level of independence. People confirmed they were supported with independence. One person told us: "Staff have definitely helped me to improve. They always make me walk, but they don't push if I am dizzy."

People's right to confidentiality was protected. Staff received training in people's rights to confidentiality in their induction training. Staff were able to describe their responsibilities in protecting people's personal information. They were aware of the provider's policy on data protection and confidentiality contained in the staff handbook. All personal records were kept in a lockable cabinet in the office and kept locked away when not in use. In people's homes, the care records were kept in a place determined by the person using the service.

Good

Is the service responsive?

Our findings

People received support that was individualised to their personal preferences and needs. The manager explained that for most people they received a detailed care plan from the local authority care manager which would be the basis for the care provided during the first visit. For people privately funded, a manager from the service would visit them, carry out an assessment of needs and agree the care that could be provided.

People's care plans were based on a full assessment, carried out prior to, or within 48 hours of, the service starting an individualised package of care. People's individual likes and preferences in the way they wanted things done were included in the care plans we saw. Staff were able to give examples of individual people's preferences which matched with the care plans. The personal assessments and care plans captured details of people's abilities and their individuality. Staff felt the care they provided was person-centred. Staff were able to describe their understanding of person-centred-care. Comments they made included: "People are at the centre of their care." "It's about how people want it to be done. It's about them not me." and "It's about making the person the centre of our attention."

Care plans included a one page relationship circle so that staff could see which relationships and social activities were important to the person in their life. We saw one recent telephone check, that had been carried out by staff, where the person using the service had said they felt the overall service was excellent. They had commented they were: "Very happy with the care I receive from Abicare."

People told us staff would do anything they were asked when they were with them. One person told us: "They always ask if there is anything else they can do." Another commented: "Staff cook my meals and it's whatever I want, it's always my choice."

Risk assessments were incorporated into individual care plan topics. Actions staff needed to take to reduce the risk had also been developed based on the person and the way that worked best for them. People's needs and care plans were regularly assessed for any changes. The care plans we saw had all been reviewed within the previous six weeks. This was to check the person's needs had not changed and the care plans were up to date.

People's changing needs were monitored and the package of care adjusted to meet those needs. Staff explained how they would report any changes to the office, write the change in the daily notes and contact other staff to advise them of the changes where necessary. Staff told us they would do things differently if people asked and would ask the office to change the care plan if needed. One person told us: "I have been able to change the times to suit my life." Other people and relatives said they were able to change times of visits on request.

People were provided with an information pack at the start of their package of care. The information pack provided details of how to contact the office and how people could complain or raise concerns. Two people told us they had no contact numbers for the service and one person said they did not know who to call in the event of a complaint. These comments were passed on to the managers during the inspection. The managers planned to make sure all people had that information available.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had not managed the service since March 2015. The community team manager had been managing in her place, with the support of the area manager. The company was currently recruiting a new manager. The area manager had started the process to become registered with us in the interim.

People benefitted from receiving a service from staff who worked well together and felt management worked with them as a team. Staff felt they were kept informed of any changes in the support people received and felt managers took prompt action when notified of any concerns relating to people's needs.

Quality assurance survey forms were sent to people annually to assess their satisfaction with the service. The forms asked questions relating to different aspects of the service provided. For example, questions related to: the planning and delivery of their care; whether staff were friendly, polite and respectful; whether staff kept them comfortable and safe and whether staff understood their care needs. We saw the results of the 2014 quality assurance survey. The area manager told us the 2015 survey was due to start soon.

The area manager carried out monthly audits which looked at samples of staff files, care plans, accidents, incidents and health and safety in the office. Any issues raised by the local authority contracts team were passed to the area manager to investigate. For example, reports of missed calls. We saw in the complaint log a report of two recent missed calls. The service had determined the cause and taken action to reduce the risk of the same happening again.

The area manager told us team staff meetings would usually be held every six weeks but there had not been one since February due to the registered manager leaving. They planned to re-introduce them soon.

Care plans, daily records and risk assessments were reviewed three months after the start of the service, then six monthly or if people's needs changed. Staff checked the care plans each visit and managers checked them when they provided cover or visited people. Systems were in place for the area manager and service manager to oversee and monitor staff training. A log was kept of what training staff had received or needed to be booked on.

All of the service's registration requirements were met and the manager was aware of incidents that needed to be notified to us. Records were up to date, fully completed and kept confidential where required.

Staff told us they were not always able to reach their calls at the scheduled times. They told us this was due to no travel time being allowed between visits and that the visits were booked back to back. For example, their first call of the day may be at 8.15am for 45 minutes and the next call would be scheduled for 9am, even though it may take 20 minutes to drive to the second call. The area manager and community team manager confirmed travel time was not worked into the staff schedules. They explained they had a "15 minute leeway" agreement with people, meaning they could arrive either 15 minutes before or after the scheduled time. However, staff explained the lack of travel time meant there was a knock-on effect and that staff were progressively later with each call they attended. The first call of the day or their group of calls, were the only ones they felt they could be on time for.

Two people told us staff arrived on time, they commented: "They are normally on time, they help me to wash myself and encourage me to dress myself" the second said: "They come on time, they stay the right amount of time, I am very happy with them." All people said staff stayed the correct amount of time and didn't rush them.

However, six people and three relatives told us they were dissatisfied with the care workers' time keeping. One relative told us they had made complaints to the office about time keeping in particular and were not satisfied with the outcome. Another relative told us staff timekeeping was poor and said: "one time they arrived at 7.30am instead of 8.30am and another time was 6.15pm instead of 8pm". They told us they felt the unpredictable system was giving them stress. Other comments received included: "They arrive at varied times, sometimes quite late but they never rush me." and "It is never the agreed time, and it gets later and later." People told us they were not called to say the staff would be late or what time they would be arriving.

We recommend that the service explores the reasons for late calls and takes action to improve their practice accordingly.