Astoria Homecare Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Astoria Homecare Ltd is a domiciliary care agency providing personal care and support to people living in their own homes. The service is registered to offer support to older and younger adults, adults with learning disabilities, physical disabilities and people with mental health needs.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of the inspection, 18 people were receiving support with personal care.

People's experience of the service and what we found
Overall, the service was able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture, but we found a number of areas where improvements were required.

Right Support
In terms of consent to care, people were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Staff focused on people's strengths and promoted what they could do. Staff communicated well with people.

Right Care
We found risk assessments and risk mitigation plans were not always in place. Medicines were not always managed in a safe way. Staff understood how to protect people from poor care and abuse and the service worked with other agencies to do so. Staff promoted equality and diversity in their support for people. They understood people's cultural needs and provided culturally appropriate care. The service had enough appropriately skilled staff to meet people's needs and keep them safe. People were supported to access healthcare services.

Right Culture
The provider had systems to evaluate the quality of the service being delivered, but these were not always effective as they had not found the concerns identified during the inspection. The values of the organisation, management and staff helped people to feel included and empowered. Staff were supported through supervision and training and told us they felt supported by the registered manager.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk.

Rating at last inspection
The last rating for this service was good (published 15 March 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We undertook a focused inspection to review the key questions of safe and well led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Astoria Homecare Ltd on our website at www.cqc.org.uk.

During the inspection we found there was a concern with consent to care, so we widened the scope of the inspection to include the key question of effective.

Enforcement and Recommendations
We have identified breaches in relation to safe care, consent to care and good governance. We recommended the provider consider current guidance around safe recruitment and establish systems to help ensure lessons are learnt and to take action to update their practice accordingly.

Please see the action we have told the provider to take at the end of this report.

Follow Up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Astoria Homecare Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 2 inspectors 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was announced. We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, including notifications of significant events. We contacted the local authority to ask for feedback. We used the information the

provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included 4 people's care records and 3 staff records. A variety of records relating to the management of the service were also reviewed. As part of the inspection, we spoke with 5 people who used the service and 6 relatives. 12 care workers and 3 health and social care professionals emailed us feedback of their experience of the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
• The provider did not always assess risks to ensure people were safe. Risks were not always identified, and when they were, they were not always detailed enough. Risk mitigation plans were not always in place.
• The medicines for one person lacked a risk assessment for the administration of the medicines and there was no supporting information about the medicines which meant staff lacked clear guidance.
• Another person did not have risk assessments around mobility, falls or personal care. Staff were able to access information on an app, but it was basic. For example, it indicated the person required support to move but did not indicate how many staff were required for transfers, or how the transfers were done. The app also indicated the person had a health condition, but there was no information for staff in the care plan to explain what this condition was or how it affected this person.

Systems had not been used effectively to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Notwithstanding the above, we saw some examples of clear risk assessments and care plans.
• For example, one person had clear guidelines on the support they required around their mental health needs and mobilising.
• People's home environment was assessed to help make sure it was safe.

Using medicines safely
• People were supported to receive their medicines in a way that was not always safe.
• We looked at one person's medicines records and found they did not have a medicines risk assessment, care plan or information about what the medicines were used for and any side effects.
• The person also had prescribed topical cream but it was not recorded where on the body it was to be applied or recorded on the medicines administration records.
• The provider told us an external nurse completed medicines competency testing, but there was no record of this.
• Medicines were not regularly monitored to ensure they were being administered as prescribed.

We found no evidence that people had been harmed. However, the provider had not ensured that people were protected against risks associated with medicines management. This was a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• During the inspection, the registered manager showed us a medicines risk assessment they said they would implement straight away.

Systems and processes to safeguard people from the risk of abuse
• People were not always safeguarded from abuse and avoidable harm.
• The provider had systems and processes to help safeguard people from abuse. This included safeguarding adult and whistleblowing procedures. However, these were not always used effectively.
• The provider told us they had no incidents, complaints, or safeguarding alerts. They showed us a quality alert from the local authority regarding allegations about staff. The provider had shared information with the local authority, however, there was no evidence of how the investigation into the allegation was carried out or what preventative measures were in place to help prevent a similar situation.

We recommend the provider establish systems to effectively investigate concerns, and ensure lessons are learnt and recorded to help mitigate risks to the health, safety and welfare of people using the service and take action to update their practice accordingly.

• People and their relatives felt safe with the care they received. One relative stated, "I feel confident enough to leave [person] in their care whilst I go shopping. I know [person] will be in safe hands."
• Training records and staff confirmed they had completed safeguarding training and knew how to respond to any concerns.

Staffing and recruitment
• The provider did not always operate safe recruitment processes. We found recruitment procedures were inconsistent. For example, some staff had appropriate employment references while others did not and gaps in employment were not always accounted for.
• Where there was missing information, such as gaps in employment, there was no employment risk assessment to assess the gaps in information, or any description of measures to be taken to ensure people's safety.
• This meant we were not always assured new staff were suitable for the work they were undertaking.

We recommend the provider consider current guidance around safe recruitment and take action to update their practice accordingly and apply the guidance consistently.

• The provider had recruitment procedures in place, and although not consistent, staff recruitment records included application forms, references, identity checks and confirmation that Disclosure and Barring Service (DBS) checks had been carried out. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• We did not identify any other issues with recruitment and the service had a stable staff team.
• The provider ensured there were sufficient numbers of suitable staff.
• People and relatives confirmed the staff arrived on time and stayed for the full length of the visit. A relative told us, "They are on time. Sometimes they stay over their allocated time if [person] has problems."
• Staff confirmed they had enough time allocated for them to travel to the visits and they had enough time during the visits to provide the care required by the person.

Preventing and controlling infection
• People were protected from the risk of infection as staff were following safe infection prevention and control practices.
• Staff had relevant training and were provided with personal protective equipment (PPE) such as gloves and

masks to help protect people from the risk of infection.
• The registered manager told us they completed spot checks but could not show us written evidence of spot checks that confirmed staff used PPE in a safe manner. They agreed to record this in future.

Learning lessons when things go wrong
• A procedure had been developed by the provider for the reporting and investigation of incidents and accidents. However, the provider told us there had not been any since the last inspection.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA and found they were not always.

• All four care plans we reviewed for consent to care lacked evidence the provider was consistently following the principles of the MCA.
• One person's record indicated they had the capacity to consent to their care, however we found a staff member had signed off the care plan and there was no evidence the person had been involved in their care planning. The same staff member had signed a second person's consent to care form, without the legal authority to do so and there was no indication if the person was involved in planning their care.
• Another person's relative had signed a service agreement to consent to the person's care, but there was no evidence the relative had the appropriate legal authority to do so. Additionally, other part of the care records indicated the person had the capacity to consent to their care, which meant they should have been able, or supported to, sign the consent to care documents themselves.
• The records for a fourth person indicated they had the capacity to make decisions around their care but there was no written indication they were involved in their care planning or that they consented to the care provided.

The provider did not consistently apply the principles of the MCA which meant people may not always have received care as they wished or in their best interests. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff had completed appropriate training and told us they offered people choices when providing care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed and care and support was delivered in line with current standards to achieve effective outcomes.
• The registered manager told us people's needs had been assessed prior to a service being provided to confirm their needs could be met. However, there was not always a record of the pre assessment.
• Care plans were reviewed regularly.

Staff support: induction, training, skills and experience
• The service made sure staff had the skills, knowledge and experience to deliver effective care and support.
• Staff completed induction training in line with the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.
• The provider completed face to face training as well as online training. Training specific to the needs of the people the service was providing care to included dementia, mental health needs and learning disabilities.
• Relatives were confident about staff training and told us, "[Person] has a PEG fitted. Carers have been trained specifically to meet [person's] needs. They were sent to the hospital for training". A percutaneous endoscopic gastrostomy (PEG) is a type of feeding tube. and "They understand dementia. [Person] is not the easiest person to care for. Staff are experienced in dealing with their behaviour."
• Staff were supported to provide effective care through supervision to help ensure they followed best practice.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to eat and drink enough to maintain a balanced diet.
• People's nutritional needs were recorded and met. Most people who used the service were supported by relatives with their diet.
• When people required support with meals, this was part of their care plan. Most people could choose what they wanted to eat and care plans contained basic information regarding preparation and serving food. Food preferences were also included.

Staff working with other agencies to provide consistent, effective, timely care
• The provider ensured the service worked effectively within and across organisations to deliver effective care, support and treatment.
• The provider worked in partnership with family members and other health and social care professionals. We saw evidence of good practice when a family member had asked for staff support for a physiotherapist visit and staff had attended when it was not their scheduled time.
• We also overheard a conversation between the registered manager and staff indicating they knew what action to take if the person they were supporting presented as unwell.

Supporting people to live healthier lives, access healthcare services and support
• People were supported to live healthier lives, access healthcare services and support.
• Staff reported any health care concerns to the office who alerted appropriate health care professionals and commissioning bodies.
• Records contained information of professionals involved in people's care such as their GP, pharmacist, district nurse and occupational therapist.
• A health care professional told us, "Astoria are very responsive and flexible. For example, they are able to arrange a home visit on the same day that we make a request, providing us with a very good service. [The registered manager] is easily contactable and will come back the same day to a query. They follow devised

care plans very closely and will feed back any concerns or successes."

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• The provider had a clear management structure but it was not always clear how the quality of care to drive improvements in service delivery was monitored. There were systems for monitoring and improving the quality of the service but these were not always implemented effectively as the provider's systems had not identified the issues seen during the inspection.
• The provider had not identified all risks, for example for the administration of medicines and for falls. Additionally, mitigation plans were not always in place. This meant the provider did not have appropriate guidance in place to improve people's care. Audits had not picked this up.
• The registered manager told us an external nurse completed medicines audits and spot checks were undertaken, however they had no written evidence of these.
• It was not clear how lessons learnt were used to help mitigate future risk and improve service delivery.
• Checks had not identified the MCA 2005 was not being implemented as is the legal requirement. The registered manager had not identified consent was not evidenced in people's records and people without the legal right to do so, had signed to consent to people's care.
• There was a lack of audits and checks on service delivery which meant the provider did not have a clear overview of the service and could not identify where improvements were required.

We found no evidence that people had been harmed. However, the systems were not robust enough to demonstrate service improvement was effectively managed. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People and their relatives knew who the managers were and felt able to raise concerns with them.
• The registered manager and the nominated individual, who were actively involved in the day to day running of the service, had appropriate qualifications and experience in care.
• The provider had a range of policies and procedures in place to support staff in delivering a good level of care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The provider had systems to provide person-centred care that achieved good outcomes for people. However, these needed to be implemented more effectively to ensure care records had enough detailed guidance for staff in relation to people's preferences and support needs.

• There was a positive and open culture at the service.
• The registered manager and nominated individual told us their ethos was person centred and revolved around the people they supported. They aimed to offer a flexible, responsive and person-centred service to people and their families, always consulting and never assuming people's needs and preferences.
• They explained they offered a consistency of staff and introduced care workers, who spent time observing and getting to know the person. This helped the person and the care workers build a positive working relationship.
• Relatives told us people received appropriate support and spoke positively about the care provided. Comments included, "When [person] refuses care, staff use gentle persuasion. They don't shout, they talk softly and they are very patient. [Person] has a good team of 5-6 regular carers who know them very well" and "Everything they do, is done with care. Care workers understand [specific] cultural aspects of [person's] life."
• Staff felt well supported and were happy working there. One care worker said, "My manager provides support by offering regular check-ins to discuss any challenges and concerns I may encounter while providing care. They ensure I have access to necessary resources, training and guidance to enhance my caregiving skills and by constant supervision in the office."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The provider understood their responsibilities under the duty of candour.
• They knew it was a requirement to notify appropriate agencies including CQC if things went wrong.
• The registered manager explained they were open and honest when things went wrong. They accepted what happened, took responsibility and took action to get things right.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and staff were involved in the running of the service and fully understood and took into account people's protected characteristics.
• People's diverse needs such as culture, religion and language spoken were considered and where possible, people were matched with staff from similar backgrounds to help ensure people felt supported by staff who understood their language and needs.
• A health care professional told us, "For people who are happy with where they live and have a strong wish to stay put, rather than considering any form of supported accommodation, the Astoria service has been a game-changer. The combination of flexible, highly personalised support and skilled, caring staff makes it possible for clients to retain their independence while also remaining safe and well, with access to urgent mental health care at the first signs of becoming unwell."
• Satisfaction surveys were undertaken to get feedback from people and their relatives about what was going well and what could improve service delivery.
• Team meetings were held to share information and give staff the opportunity to raise any issues. One staff member confirmed, team meetings "give us time to all communicate together and discuss common issues that may arise in the workplace. We also get asked our views and anything that can be changed to make working life better."

Working in partnership with others
• The provider worked in partnership with others.
• Care records confirmed the provider worked with families and health and social care professionals. The registered manager and nominated individual explained they worked closely with the local authority's mental health team and had built a good working relationship with them.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered persons did not always ensure that the care and treatment of service users was provided with the consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons did not always assess or do all that was reasonably practicable to mitigate the risks to the safety of service users. The provider did not always ensure the proper and safe management of medicines. Regulation 12 (1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons did not always have effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17 (1)