Abhi Rose Ltd

# Abhi Rose Homecare

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| 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? | **Requires Improvement** |

# Summary of findings

## Overall summary

The inspection of Abhi Rose Ltd took place on 23 November 2017 and was announced.

This was the service's first inspection since their registration with the Care Quality Commission during March 2016.

Abhi Rose Ltd is a domiciliary care agency that provides personal care for adults. People who use this service have a wide range of needs including older people who are living with a diagnosis of dementia, mental health needs, learning disabilities and physical disabilities. At the time of our inspection 24 people were receiving support from this provider.

The service had a registered manager in place. 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.

During this inspection, we identified the service was in breach of regulations in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems and processes were not in place to monitor and improve the quality and safety of the service.

Staff had received training and assessed competent to administer medication. Medicine supporting documents were not retained with the medicine administration record (MAR) for audit purposes. We found medicine administration records were not audited on a regular basis.

People and their relatives told us they felt safe. Staff had received safeguarding and whistle-blowing training and knew what to do to keep people safe.

Safe processes were in place for the recruitment of staff. Risk assessments were in place and people were protected from the risks association with infection control.

People received effective support and care. People and their relatives felt staff had the right skills to do their job effectively. Staff received induction and appropriate training.

People were supported to main independence and have control of their lives. People were supported to maintain their religious beliefs.

Mental capacity assessments were in place in care plans and staff demonstrated a good understanding of the principles of the MCA and how this related to their daily duties.

People we spoke with told us staff were caring. Staff treated people with kindness and compassion. People

were supported to remain independent.

Care and support plans were person centred and detailed. Care plans took into account people's religious, ethnic and cultural needs. People and relatives were involved in their care planning. People's privacy and dignity was respected. Care plans and records were securely stored.

Care plans were reviewed on a regular basis and updated when necessary.

The service had a complaints policy in place. People and relatives told us the service would contact them by telephone to see if they had any concerns. People told us the service was well led.

People were supported at the end of their life. The service had an end of life policy in place.

We found audits were not undertaken to review and improve the service provided.

Staff told us there was an open culture and felt supported by the managers.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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?

**Requires Improvement**

The service was not always safe.

People told us they felt safe and staff understood the signs of potential abuse.

Medicine administration records were not audited consistently.

Risk to people were considered and risk assessments were in place.

### Is the service effective?

**Good**

The service was always effective.

People were supported to maintain their cultural and religious beliefs.

Staff supervisions and appraisals were carried out in line with organisational policy.

Staff had received induction and training to carry out their role effectively.

### Is the service caring?

**Good**

The service was caring.

People and relatives told us staff were caring and they had a positive relationship with all staff.

People were supported to live independently and in a way which was important to them.

People's privacy and dignity were respected.

### Is the service responsive?

**Good**

The service was responsive.

Care plans were person centred and people were involved in planning their support requirements.

People were supported to maintain their cultural and religious identities.

Different effective methods were used to communicate with people.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

People and relatives told us they thought the service was well led.

Development of quality assurance systems and audits were required to monitor and improve the service.

An action plan was in place to develop and strengthen the support for people who used the service.

# Abhi Rose Homecare

**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 site visit took place on 23 November 2017 and was announced. 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.

We gave the service 48 hours' notice of the inspection visit because we needed to ensure the office would be open and the registered manager would be available to speak to us. We visited the office location to see the registered manager and office staff; and to review care records and policies and procedures.

The inspection team consisted of one adult social care 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.

The expert by experience on this occasion had experience in caring for older people and people who used regulated services.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire and police service, environmental health, the clinical commissioning group, and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

During the inspection we spoke to the nominated individual, the registered manager and three members of staff. Following the inspection we spoke on the telephone with four service users, four relatives and received feedback regarding the service from two healthcare professionals.

We used information the provider sent us in the Provider Information Collection (PIC). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Requires Improvement

# Is the service safe?

## Our findings

We asked people and their relatives whether they felt safe with the care they received from Abhi Rose Ltd. People who use the service told us, "I am always safe in their company." And "I have no issues about safety." "I always feel safe and comfortable with the care workers." A relative told us "At first [Name] was very hesitant as felt uneasy but the staff have been brilliant and have won them over with their skill. [Name] has no problem now." Another relative told us "They are delightful [Name] feels comfortable with them at all times."

Staff told us they felt safe working for the service. One staff member told us "I always read the care plans before going into someone's home so that I know the person and their ways."

The registered provider had a safeguarding and whistle-blowing policy in place. Staff we spoke with demonstrated an understanding of the signs of abuse and knew to report any concerns to the registered manager. This meant people who used the service were protected from the risk of abuse as staff understood their responsibilities to keep people safe.

Some people received support to take their medicines. Staff told us they received training for the administration of medicines and following their training would be competency assessed to ensure they were safe to administer medicines. One person told us "My medicine is given to me on time. They have it written down what they should give me." A relative told us "The medication is given on time. I know, as the medication has to be removed from the pack. I check this every night as I give my relative the last tablet so I know what has been given during the day. There is a list of medication."

Medicine administration records (MARs) were used to record the administration of medicines. We looked at a sample of MARs that had been returned to the administration office and saw gaps in recording, for example, one medicine required to be taken three times a day had not been administered midday on four occasions during October. We raised this with the registered manager on inspection who told us the person had attended social events on these days and the service had not provided support. They further stated they had discussed this with the person's dietician as the medicine was diet related and were told the medicine could be occasionally missed. We noted there was not documentary evidence within the care plan to support this advice and advised for written clarity to be sort from the dietician. This meant the person may not be receiving their medicine as prescribed.

We looked at another MAR and saw a person's medicines were supplied in a monitored dosage system (MDS). A MDS is the method whereby medicines for a person for each time of day are dispensed by the pharmacist into individual trays in separate compartments. We saw the MAR stated 'as dosette box' but did not include any supporting documentation regarding what medicines were contained in each tray. This meant there was not an accurate record retained within the MAR detailing the medicines being administered.

We found a lack of auditing for MARs and concerns had not been identified before we brought these to the

attention of the registered manager. We looked at MAR audit information and saw this had last been completed in July 2017. This meant there was no recent quality review for the oversight for the safe administration of medicines.

This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems and processes, for example, regular audits were not in place to monitor and improve the quality and safety of the service.

We found evidence relating to incident reporting and shared learning from the review of themes and trends. The nominated individual explained the service had an 'open house' environment where staff members met each morning at the service's offices for breakfast to share best practice and day to day concerns. We looked at a recent incident and saw this was dealt with appropriately. This meant there was an established process in place to share the lessons learnt or document changes to the service.

Care plans included specific risk assessments relating to people, for example, risks relating to health and safety, medicine administration and home assessments. We saw one person had been identified as having a high risk from falling and the care plan contained a detailed risk assessment addressing potential fall risks. This meant the person was protected from the risks associated with falling.

It was evident risks relating to staff providing care in people's homes had been incorporated in the overall care plan. Each care plan we looked at contained a home risk assessment detailing lighting, stairs, flooring and smoke detectors. We noted the service reviewed whether people had smoke and carbon monoxide detectors installed in their homes. Where these were found to be missing, the service liaised with the local fire department on behalf of the person to arrange for a fire reduction check to be carried out in the person's home. This meant people were protected from risks associated with fire and carbon monoxide within their own home by the additional support provided by the service.

We looked at staff rotas and saw these showed the consistency of staff providing support to people. We saw care support calls were organised into established 'service runs' and the same staff were allocated to the service runs. Rotas showed staff who were new to the service shadowed more experienced staff members until they were signed off as competent to provide care and support to people. This meant people received their support from staff they were familiar with and who knew their individual needs.

We checked staff had been recruited in a safe way and that all the information and documents as specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were in place.

We reviewed the recruitment files for three members of staff. We found application forms had been completed and Disclosure and Barring Service (DBS) checks had been obtained. DBS checks return information from the Police national database about any cautions, convictions, warnings or reprimands and help employers make safer recruitment decisions to help prevent unsuitable people from working with vulnerable groups. We noted one application form had a gap in employment history. Potential gaps in employment history should be discussed in detail to enable a full understanding of previous work experience. We brought this to the attention of the registered manager during inspection.

All staff we spoke with said they felt confident in raising concerns with either the registered manager or nominated individual and that any concerns would be reviewed and actioned if appropriate. This helped demonstrate there was an open culture and a willingness to learn from lessons learnt.

People were protected from risks associated with infection control. Staff had access to personal protection

equipment. People we spoke with all told us there were no issues with infection control and all staff wore appropriate gloves and aprons when providing personal care.

Good

# Is the service effective?

## Our findings

People told us staff had the skills to enable them to do their job effectively. One person said, "[Name] is brilliant, fully trained and skilled and always goes the extra mile for me. [Name] is more like a friend." Another person said "They do all the tasks with skill. I have no issues about the care workers not being trained." A relative told us "They are brilliant. [Name] moves very slow and staff take their time with them."

In each of the care plans we reviewed we saw a contract for the care package being provided signed by the person or their authorised representative.

Care plans recorded a person's cultural, ethnic and religious beliefs. For example, one care plan recorded a person's wish to only have male carers and stated all visitors to the person's home would need to wear shoe covers to respect floor coverings for religious reasons. We saw the care plan detailed the person's requirement to be washed using the Islamic procedure for washing parts of the body. Staff told us they had received training on different cultural needs and practices. This meant people's cultural and religious beliefs were respected when making care and support decisions.

Staff received induction and mandatory training. Staff new to the organisation were required to complete a staff induction workbook, shadow experienced staff on care visits and undertake mandatory training.

We looked at the training matrix and saw staff had completed mandatory training. The nominated individual told us training was provided via NCFE, a registered educational provider. Two members of staff we spoke with told us they had completed elements of mandatory training requirements, for example, dementia awareness as part of previous employment prior to joining Abhi Rose Ltd. We saw training certificates were included in staff files. This meant staff received appropriate training to enable them to carry out their roles effectively.

We noted the service was in the process of changing recording systems from a paper based system to an electronic system and saw data being input onto the electronic system on the day of inspection. We noted there had been a gap in recording of supervisions as a result of the data transfer process and there was not an overall matrix in place that recorded staff supervisions had taken place. The registered manager told us they would look in the individual staff files on a monthly basis to see which members of staff required supervisions. We saw supervision notes in the files we looked at. After the inspection we were provided with a handwritten summary detailing dates staff supervisions had taken place and the date for the next supervision. This meant staff received supervisions in line with organisational policy.

There was an annual staff appraisal system in place. We saw staff had received an annual appraisal and this was documented and retained within the staff file. This meant staff received feedback on their work performance.

Some people who used the service needed support from staff in relation to their nutrition and hydration needs. The records seen were very detailed and recorded a person's cultural and religious requirements. We

saw one person required a halal diet and records stated their family would prepare the person's meals beforehand. Another person's care plan stated they always ate a ham sandwich at lunch time with a drink of tea. People we spoke with told us food was made to their standards. This meant people were supported in relation to their nutritional needs which was specific to their individual requirements.

The registered manager told us they would refer a person to another service if they felt the person's needs had changed and other organisations needed to be involved. They described an instance when a third party had raised a concern direct with care staff about a person using the service and as a result they had contacted the person's social worker. A best interests meeting had been held to discuss these concerns and the person's care plan had been changed as a direct result. This demonstrated effective working with other organisations.

Each of the care plans we looked at recorded details of the person's doctor and other relevant healthcare professionals. The registered manager told us they would have no hesitation in contacting a person's doctor if the person was unwell and unable to do so themselves. This meant people would receive support to access help from healthcare professionals when required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this is called the Deprivation of Liberty Safeguards (DoLS). For this type of service any applications to deprive a person of their liberty must be made to the Court of Protection.

The MCA also provides the legal framework for acting and making decisions on behalf of people who lack capacity to make particular decisions for themselves. Where a person lacks capacity to consent, then nobody should sign a consent form unless they have specific legal powers to do so, for example, health and welfare lasting powers of attorney.

MCA assessments were in place in the care plans we looked at. We saw one person had a DoLS in place which enabled care staff to safely restrict the person's movement in their best interests between the staff daily scheduled visits and this was documented within their care plan. This demonstrated care was being provided in a way appropriate to the person.

Staff demonstrated a good understanding of the MCA and were able to explain how the MCA related to their daily care duties. Staff told us they would promote people to be independent and gave examples of how they would achieve this. One staff member described how they would encourage a person to wash their own hands and face. Another staff member told us how they would encourage a person to put bread into the toaster rather than do all the tasks themselves. This meant people were being supported to live as independently as possible.

Good

# Is the service caring?

## Our findings

People who used the service told us; "They are very good, they make me happy", "The most kind, caring care worker I have ever had. I always look forward to seeing [Name]" and "Marvellous, brilliant care workers. Always caring, kind and always respectful to me."

Relatives told us "Brilliant, experienced and very caring care workers. They are more like friends to my relative", "Brilliant. Very caring" and "Staff treat [Name] like their own parent".

Staff we spoke with told us how they would support people and spoke in detail about different peoples support needs. Staff described how they would encourage a person to carry out some tasks themselves and provide support where necessary. This meant people were supported to live as independently as possible.

Staff treated people with kindness and compassion. All relatives we spoke with told us staff were caring. One relative told us "Staff are brilliant really kind and caring. They give my relative a hug when they need one."

The registered manager told us they employed a diverse workforce from different ethnic backgrounds and as such the service were able to provide staff who were able to communicate with people in a different language if this was requested. They said the service had received positive feedback from people and their relatives regarding staff communication skills. A relative told us "Staff speak the same language as [Name] which makes a great difference to them." This meant people could choose to be communicated with in a language of their choice.

People and their relatives were asked and involved in the care planning. The registered manager told us care plans were updated on an annual basis or when a person's needs changed. We saw the care plans were person centred and extremely detailed and reflected updated information. A relative told us "The managers are very good as they keep in touch with us. We have been through the care plan and they always keep us in the loop." A healthcare professional told us "the managers displayed high levels of customer care in cases where I have worked with them and have demonstrated good levels of strength based and person centred care."

Consideration of people's religious, ethnic and cultural needs were reflected in care plans. One plan detailed the importance of religion to the person in all their daily living and reflected how this needed to be put into practice. We saw equality, diversity and cultural awareness formed part of the staff induction process. A staff member told us "A person's cultural needs are shared with us before we visit a person."

Care plans we looked at were very detailed and person centred. We saw a person's likes and dislikes were recorded. In one care plan we saw a person's wish that staff must ensure the person wore their glasses and looked respectable before staff left. This meant people were supported in their personal appearance in a way that was important to them.

People who used the service had regular contact with their families and formal advocacy services were not

used.

We looked at a care plan and saw the person described as very independent. The plan detailed the person's expressed wish to remain as independent as possible and stated if the person required further assistance with a task whilst staff were providing support they would ask directly. We saw living in their own home was extremely important to this person and this wish was reflected throughout the plan. This meant the person was supported in a manner appropriate to them.

Staff we spoke with understood the importance of maintaining people's privacy and dignity and gave examples of how they would implement this. Staff described how they would ensure curtains were drawn and doors closed before carrying out personal care. One staff member told us they would chat to the person whilst supporting them to wash to make the experience as friendly as possible to try to out the person at ease.

Care plans were securely stored. We saw care plans and records were surely stored in lockable cabinets. Staff understood the importance of confidentiality and how this was important to their role. People and relatives we spoke with had no concerns regarding any breaches in confidentiality.

Good

# Is the service responsive?

## Our findings

One person who used the service told us, "The management are brilliant. When my regular care worker could not come, they came to see me personally to introduce me to the cover care worker and they asked me if I was happy with this." Another person said "The management come to see me and keep in touch by the telephone. It is a good relationship."

A relative told us "I have a great relationship with the management. They are very approachable and they keep me up to date with what is happening."

We looked at the care plans for four people who used the service and saw detailed assessments based on people's needs and support they required. Each person had a person centred care plan which had developed in line with the person requiring the support and if appropriate their relatives. The care plans described what a person liked to do and what support they required. We saw one plan detailed a person would lunch with their parents every Friday followed by afternoon prayers at the mosque and the person's support plan had been organised around this weekly activity. This example showed that people were supported to maintain both their religious identity and relationships with people that mattered to them.

The registered manager told us care plans were reviewed when a person's needs changed or on an annual basis. People and relatives we spoke with all told us they were involved in the care planning and had regularly reviews. A relative said "They are very good and they keep in touch with us. We have been through the care plan and they always keep us in the loop." Staff told us they reported changes in people's needs to the registered manager and this would result in the care plan being reviewed. A healthcare professional told us "I have always found the registered manager very helpful and reactive to new plans or problems."

People were supported to maintain their interests and activities. In a care plan we looked at we saw the person was supported to attend their place of worship twice a week and this would include lunch at the church. The care plan detailed the person required support to maintain their religious beliefs in line with their wishes and this included support with rituals around prayer.

The service used different effective methods to communicate with people. In a care plan we looked at we saw the person used communication technology to help staff understand their needs and wishes. This meant people were supported to communicate in a way appropriate to their needs.

The nominated individual told us the service was looking at developing a memory book for people showing individual life histories including people's personal family photographs. We saw a carer focus group had been established but not yet met, to review how this could be developed in consultation with people and their relatives. We noted this initiative was at the initial development stage on the day of inspection.

There was a complaints policy in place. We noted there were no formal complaints at the time of the inspection. The registered manager told us they would telephone people to discuss any concerns or issues a person or their relative might have. People and relatives we spoke with confirmed the provider would

telephone and deal with any issues they had. One person told us "They are absolutely brilliant and do an excellent job through the care workers. They always pick up the telephone and deal with any issues we have. They are so understanding."

The registered manager told us they worked in partnership with another organisation to support people at the end of their life. We looked at the end of life policy. We saw detailed care support plans ensured two carers would provide the care and support people needed. We looked at a thank you card from a relative the service had received following the death of a person that said 'you made end of life care as good as it gets.' This showed people and their families received appropriate support.

Requires Improvement

# Is the service well-led?

## Our findings

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of our inspection and therefore this condition of registration was met.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. During our inspection we did not identify any issues which the registered provider had failed to notify us about.

Everyone we spoke with told us the service was well led. One person told us "They are brilliant. I would recommend the service." Another person said "I am very happy with management as they are wonderful to deal with."

A relative told us "The company is ran well. They provide same language speakers and is a good service to us and to [Name]."

Another relative said "Brilliant relationship we have with management. Their hard work gives me assurance and above all gives me a break which I need."

Staff we spoke with all said they felt supported. One staff member told us "I am happy to work for the organisation." Another staff member said "I like it here. It has a lovely atmosphere and staff are great to work with."

We found there was an overall lack of auditing processes in place. An audit is an import part of the quality review and enables the provider to monitor the quality of the service being offered. As highlighted in our inspection, audits of medicine administration records had not been carried out since July 2017 which highlighted there was no manager oversight on the safe administration of medicines.

We found there was limited evidence of an effective quality assurance system to ensure learning from current performance and drive continuous improvement within the service and this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A staff member told us they felt communication in the organisation was good and there was an openness to learn from mistakes. They further told us the service encouraged staff to take regular breaks and to come into the office on a daily basis. The nominated individual told us the kitchen area with the office building was established as an informal meeting/peer support space. They stated the service provided light refreshments for staff and encouraged staff to use the facilities throughout the working day and liaise with office based staff. On the day of inspection we saw three staff calling into the office kitchen to use these facilities. This meant staff were offered an environment where they could keep in touch with each other and this offered support for effective communication in their daily working routines.

The registered manager told us the service had significantly expanded over the past six months and had increased in the number of people it supported and the number of staff employed. Staff meetings were held throughout the year but not on a regular basis. We noted a staff meeting was held in November and 13 staff had attended. We saw staff had been spoken with regarding the importance of accurate recording in daily log books and reminded to ensure there was an adequate supply of personal protection equipment within people's homes. We were told staff who were unable to attend the meeting would be given a copy of the minutes and the content of the meeting would be discussed when they next came into the office. A staff member we spoke with told us they had not attended the meeting and confirmed they had been informed of the discussions. This demonstrated all staff were kept informed of the matters discussed in the staff meetings.

People who used the service were asked to provide feedback on the service they received. We saw individual feedback had been received in February 2017 and all feedback given was positive. The registered manager told us staff involved with the person providing the feedback would be updated. We noted there was not a process in place for the wider sharing to all staff. This meant staff were not kept updated of feedback across the whole service.

The nominated individual told us there was an action plan in place to develop and strengthen the service they offered by enabling people they supported to access to the wider community if they so wished. We saw there were plans for the service to obtain wheelchair accessible transport as additional support function to enable care staff to support people to access the wider community and create a sense of wellbeing by reducing potential isolation within their homes. This meant people would be supported in their emotional and personal wellbeing.

The registered provider demonstrated they worked in partnership with other organisations. We saw the service liaised with the district nursing team when appropriate and sort advice from other healthcare professionals.

The service had strong links within the community. The nominated individual spoke passionately about providing a local support service for people within the local community. They told us it was important for the service not to grow too large and retain the personal touch.

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 17 HSCA RA Regulations 2014 Good governance<br><br>Effective systems and processes were not in place to improve and monitor the quality and safety of the service. Regular audits were not undertaken. |