Abletrust Care Limited

Abletrust Care

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?	Good

Summary of findings

Overall summary

This inspection took place on 23 May 2018 and was announced. Our last inspection was sin March 2017 where we identified some gaps in staff files and we made a recommendation. We rated the service as requires Improvement, due to a history of the legal requirements not being met. At this inspection, we found that improvements had been made to staff files and improvements to overall record keeping and governance had become embedded.

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, people with physical disabilities and people living with dementia. At the time of our inspection, Abletrust was providing support to eight people.

CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. Everyone using Abletrust Care receives regulated activity.

There was a registered manager in post. 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's care was planned in a person centred way and care plans reflected people's needs, as well as their preferences and routines. Risks to people were routinely assessed and plans were put in place to keep them safe. Staff helped people to identify goals and we saw evidence of people's independence being promoted through care delivery. People's care plans were regularly reviewed and the provider ensured that people were involved in their care.

Care calls were scheduled in a way that ensured people received care at the times that they were expecting it. The provider carried out regular spot checks and surveys to gather feedback and monitor staff practice. Staff had the right training and support for their roles and received regular one to one supervision. Staff were knowledgeable about their roles in safeguarding people from abuse and we saw evidence of the provider using safeguarding concerns to learn lessons to improve practice.

People told us that staff were kind and respectful when visiting them in their homes. Staff knew how to provide care in a way that promoted people's privacy and dignity. The provider carried out a variety of checks to measure the quality of care that people received. People were protected from the risk of the spread of infection and the provider carried out assessments of risks within people's home environment.

People received their medicines safely and staff regularly worked alongside healthcare professionals to meet people's needs. Staff carried out a thorough assessment of people's needs before they received a service. Where people had specific dietary needs, care was planned in this area, Staff sought consent from

people and obtained the correct legal documentation where people could not consent. We saw evidence of the provider working with relevant agencies and professionals.

People had regular contact with the registered manager and the provider had systems in place to involve people in decisions about their care. Staff felt supported by management and the provider had carried out checks on all staff to ensure that they were suitable for their roles. There was a complaints policy in place and people told us they were confident any issues that they raised would be addressed.

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.

The provider carried out appropriate checks on new staff to ensure they were suitable for their roles.

Care calls were planned in a way that ensured people received their care at the times that they were expecting it.

Risks to people were assessed and plans were implemented to keep them safe. Where incidents occurred, actions were taken to prevent them reoccurring.

Staff understood their roles in safeguarding people from abuse. We saw evidence of the provider learning lessons from safeguarding concerns.

People received their medicines safely and measures were in place to protect people from the risk of the spread of infection.

Is the service effective?

Good

The service was effective.

People were supported by staff that had the right training and support for their roles.

Staff supported people to eat in line with their preferences and dietary needs.

People's needs were thoroughly assessed before they started to receive care.

Staff worked alongside healthcare professionals to meet people's health needs.

People's consent was sought in line with current legislation.

Is the service caring?

Good

The service was caring.

People were supported by kind staff that they got along well with.

The provider ensured people were supported by consistent staff who knew them well.

Staff supported people in a way that encouraged them to be independent. People were involved in their care.

People's privacy and dignity was respected by staff.

Is the service responsive?

Good

The service was responsive.

Care was planned in a person-centred way that ensured people's needs were met and their routines and preferences were accommodated.

The provider regularly reviewed care plans to identify any changes in people's needs. Systems were in place to provide appropriate and sensitive end of life care.

There was a complaints policy in place and people knew how to complain and told us they felt confident their concerns would be addressed.

Is the service well-led?

Good

The service was well-led.

People knew the registered manager and told us they benefitted from frequent visits to check the quality of their care.

Staff felt supported by management and there were systems in place to enable effective communication between staff.

The provider carried out a variety of checks and audits to assure the quality of the care that people received.

We saw evidence of the provider working alongside appropriate agencies and the local community.

Ableturst Care

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 23 May 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection activity started on 23 May 2018. It included telephone calls to people, relatives and staff. We visited the office location on 24 May 2018 to see the manager and office staff; and to review care records and policies and procedures. Later that day, we visited one person in their home.

The inspection was carried out by two inspectors.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We used information the provider sent us in the Provider Information Return. 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.

Before the inspection we received questionnaires from four people, four staff and one healthcare professional. As part of our inspection we spoke with three people, the registered manager, two care staff and the administrator. We read care plans for three people, medicines records and daily notes. We looked at one staff file and records of staff training and supervision. We looked at records of the provider's spot checks and staff meeting minutes. We also saw records of quality assurance audits and surveys.

Good

Is the service safe?

Our findings

At our inspection in March 2017, we identified that the provider did not always gather enough information about prospective staff to ensure they were suitable for their roles. We found some staff files did not contain full work histories. We made a recommendation about recruitment checks and rated the service as 'Requires Improvement' in Safe. At this inspection, we found that the provider had taken appropriate action to address this issue.

People told us that they felt safe with the staff that supported them. One person said, "I do feel safe, they [staff] are not abrupt or rough. They are very kind." Another person said, "They [staff] make me feel safe, they're here in case I fall."

The provider carried out appropriate checks to ensure staff were suitable for their roles. Staff files contained evidence of full work histories, references, health declarations and a check with the Disclosure & Barring Service (DBS). The DBS keeps a register of any potential staff that may not be suitable to work in social care. In response to our findings at the last inspection, all staff files had been reviewed and updated. We noted that the improvements to the way staff files were kept meant that they acted as a prompt when recruiting staff, to ensure all checks were carried out.

People received their care at the times that they were expecting it. One person said, "They're always on time and they never miss a call." Another person told us, "They know I like early mornings and they are always here when I expect them." The provider kept a record of people's preferred times for visits and records of daily notes showed that these were fulfilled. Calls were scheduled within a close geographical area that meant staff could easily get to people at the times they were expecting them. Staff told us that they were allowed enough time for each call and punctuality was something that was monitored through surveys, spot checks and audits. The registered manager spoke with staff daily to ensure all calls had been fulfilled and people told us that they had never had a care call missed.

Risks to people were assessed and plans were drawn up to keep them safe. Care records contained detailed risk assessments that considered the personal risks people faced. These included their home environment, falls risks, behaviour and skin integrity. Where risks were identified, staff implemented plans to keep people safe. For example, one person was assessed as at risk of falls. To reduce this risk, staff ensured the person used their walking frame. Staff also supervised the person when mobilising and there were detailed instructions on how to support the person to use the shower safely. We noted that risk assessments were being regularly reviewed and where things changed, new plans were implemented.

The provider also routinely carried out risk assessments of people's home environments. These looked at any environmental risks such as fire or health and safety. Where people were not able to answer the door themselves safely, the provider found safe ways for staff to access people's homes. For example, one person had a keysafe for staff to gain entry to their home. A keysafe is a storage container for spare keys that has a coded lock. Information regarding the keysafe was stored safely and only accessible to relevant staff.

When accidents or incidents occurred, appropriate actions were taken to reduce the risk of them happening again. There had been very few incidents or accidents at the service in the last year, which showed that the provider had a proactive approach to managing risks. Where one person had fallen at home, records showed staff checked that they were safe and contacted the emergency services. To reduce the risk of a similar fall, the person was referred to the local community falls prevention team. The registered manager also arranged training on falls management with staff, so that they could be confident in how to respond to a similar incident in the future.

The provider learned lessons from historic incidents in which things had gone wrong. At the time of our inspection in March 2017, there was a safeguarding that had raised concerns about staff practice. The safeguarding had been closed by the local authority and they were satisfied with the action that the provider took. The registered manager had reflected on the incident and told us they had increased staffing numbers. This meant the registered manager completed less care calls themselves and enabled them to spend more time on monitoring. We noted an increase in monitoring and checks since our last inspection and people's feedback also reflected this.

Staff understood their roles in protecting people from abuse. There had been no safeguarding incidents in the last 12 months and staff were knowledgeable in this area. All staff had completed safeguarding training and this was regularly discussed at one to one supervisions and staff meetings. We tested staff knowledge on safeguarding and they were aware of how to raise any concerns that they may have. One staff member said, "I would report anything to [registered manager]. If nothing was done I would definitely take it further and call social services or CQC."

People's medicines were managed and administered safely. People told us that they received their medicines as prescribed and staff were competent when administering medicines to them. Care records contained detailed information on people's medicines, including the benefits and side effects of each medicine. Staff received medicines training and had their competency assessed. The provider regularly reviewed staff competency through monthly observed spot checks and annual refresher training. We reviewed medicine administration records (MARs) and found these to be up to date with no gaps. Where medicines had not been administered to one person whilst they were in hospital, staff had completed the MAR accurately to reflect this. The registered manager regularly audited MARs and told us that where they identified gaps, staff were suspended from administering medicines and were required to attend training again and be re-assessed for competency.

People were protected against the risk of the spread of infection. People told us that staff used personal protective equipment (PPE) when providing personal care and they regularly washed their hands. Staff were trained in good practice in relation to infection control and this was something that the provider checked during monthly spot checks. The registered manager told us that they regularly discussed with staff the importance of leaving people's home environments clean and hygienic and people told us that staff always maintained cleanliness at their homes as well as delivering personal care.

Good

Is the service effective?

Our findings

People told us that they were supported by staff that were trained to meet their needs. One person said, "I receive such a good service from [staff member]. They all know what they're doing." Another person said, "They [staff] are all very good."

Staff went through an induction when they came to work at the service and completed mandatory training courses that were regularly refreshed. One staff member said, "The induction was really good, it was three weeks and I didn't go out in the field until I'd completed it all." Records showed staff completed training in areas such as moving and handling, health and safety and food hygiene. Training was provided through e-learning as well as face to face in-house training. The provider had equipment and expertise to conduct moving and handling training in-house and staff told us that this was particularly useful as they supported people who required support and equipment to move. People told us that staff were competent when using equipment to support them.

Staff received regular one to one supervisions and records showed these were used to discuss people's needs and any relevant training. One staff member said, "[Registered manager] regularly comes out into the field and carries out observations, we have supervision every six to eight weeks." The registered manager also observed staff practice each month at spot checks and these were used to prompt discussion at supervision. Staff told us supervisions were meaningful and they could make requests about training. One staff member said they had recently requested training in managing people's money and this had been arranged and completed. An annual appraisal also took place and records showed that these were used to identify aims for each year.

People were happy with the food staff prepared for them at home. One person said, "They [staff] help make my lunch and they make a good sandwich." People's care records contained information about the foods they liked and the support that they needed to prepare meals. One person liked a particular breakfast cereal each day. This was in their care plan and staff were knowledgeable about this preference. Where people had particular dietary needs, these were met by staff. For example, a healthcare professional had noted one person had been losing weight. In response, the provider reviewed the person's care plan and increased support to encourage the person to eat. Daily notes showed that staff kept a record of what the person had eaten to reassure relatives and to help inform healthcare professionals.

Staff worked alongside healthcare professionals to meet people's needs. Records contained evidence of staff contacting healthcare professionals whenever necessary. For example, staff noted that one person's mobility had worsened. This had made it harder for the person to move around their home and have a shower. Staff contacted an occupational therapist (OT) who prescribed equipment to the person to make mobilising easier. The person's care plan had been updated to include the use of equipment to support the person to use the shower. Records also showed staff contacting people's GP or community nurses when required.

The provider identified people's needs and choices when they were new to the service. One person told us,

"[Registered manager] came in first to see me." People told us that they received an assessment before receiving a service and we found these in people's records. We noted that assessments were thorough and captured any risks and people's needs in relation to areas such as personal care, mobility and nutrition. Assessments also detailed people's preferences and routine. Information from assessments was added to people's care plans and we saw that it was fulfilled. For example, one person's assessment stated that they used equipment to mobilise and also wore glasses. This information was added to the person's care plan and daily notes showed this was fulfilled.

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.

We checked whether the service was working within the principles of the MCA and found that where necessary, it had been applied appropriately. All but one person receiving a service had been able to consent to their care and they had signed for this. Where one person was not able to consent, a relative had signed on their behalf. The provider had obtained copies of documentation to confirm their legal status to do so.

Good

Is the service caring?

Our findings

People told us that they were cared for by kind staff. One person said, "They [staff] are very caring." Another person said, "They're all very nice." Another person told us, "They are all very good and really nice people."

People were supported by regular staff that knew them well. People told us that they were supported by consistent staff and that this enabled them to get to know them. The provider scheduled calls in a way that ensured the same staff regularly completed people's care calls and we noted that people's daily records confirmed this. Staff were knowledgeable about people's needs and preferences. For example, one person was living with dementia which caused them to sometimes forget what time of day it was. Their care plan recorded that staff were to use prompts and notes to guide the person. A staff member was knowledgeable about this, they said, "For example, we leave a note on [person]'s hair brush to remind them to brush their hair. We use prompts and reminders so they know the time of day."

People's ability to do tasks independently was encouraged by staff. One person told us, "They [staff] watch me while I stand up but they let me get on with it, they are standing by if I want them." People's care plans reflected their strengths and the support that they required to be independent. For example, one person's condition fluctuated and this meant they were sometimes not able to prepare drinks and snacks. Their care plan reflected this and staff asked the person daily if they required support with these tasks. On days that the person was able to complete tasks independently, staff recorded that they had done so.

Staff involved people in their care. One person told us, "I tell them what I like and they always do it." The provider kept a record of people's preferences and people told us that these were fulfilled. For example, one person's care plan reflected the type of clothing they liked to wear and staff offered them daily choices in line with this preference. Records of reviews and surveys showed people were regularly asked if they were happy with their care and if there was anything that they wanted to change.

People were encouraged to maintain important relationships. Care plans showed that relatives and healthcare professionals were involved in planning care. The provider ensured systems of communication were in place and relatives had regular opportunities for input. For example, records showed staff had contacted relatives where they had notice one person had become unwell. People's daily notes were accessible to relatives and the registered manager frequently spoke with relatives as a part of reviews and surveys.

Staff were respectful of people's privacy and dignity when providing care to them in their homes. People told us that staff always knocked before entering, even where there were systems in place for staff to allow themselves entry safely. Staff had training in promoting dignity through care and the registered manager was a dignity champion. We saw that this was discussed at meetings and supervisions and staff were knowledge able about how to provide care in a respectful and dignified manner. One staff member said, "We're mindful that it is people's homes so we always knock and tell them why we are there."

Good

Is the service responsive?

Our findings

People told us that they received personalised care. One person said, "They [staff] help me get to my frame and get me ready for the day." Another person said, "They [staff] do everything that I need, they are very helpful."

People's care was planned in a personalised way. Care plans contained information about people's needs and what was important to them. The provider helped people to identify goals and we saw evidence of outcomes being achieved for people. For example, one person started using the service and had difficulty moving around their home. The person often used a wheelchair and wanted to develop the strength and confidence to be able to use the shower. Staff supported the person to access equipment and a care plan was drawn up to provide encouragement and support to the person. Daily notes and correspondence from healthcare professionals showed this had caused improvements to the person's mobility and less use of the wheelchair when staff supported them. People's routines were documented and we saw that where people had requested specific preferences, such as times for calls, these had been fulfilled.

People benefitted from regular reviews. The registered manager carried out frequent review visits and records showed that these were used to identify and action any changes to care plans. For example, one person was living with dementia and had shown signs of increased confusion. In response to this change in the person's needs, their care plan was updated to include that staff could use pictures to divert the person if they became anxious. There were particular photographs that the person responded positively too and this was noted in the review. We also saw that the community psychiatric nurse had visited the person and the provider had requested a review from social services which was pending.

Systems were in place to ensure that people received appropriate and sensitive end of life care. At the time of our inspection nobody was receiving end of life care. We noted that people's preferences with regards to end of life were recorded, such as whether they wished to be admitted to hospital and which relatives to be contacted. The provider's policy was to carry out a reassessment where people were to receive end of life care and we saw that paperwork was in place to carry this out should a person's needs change.

The provider ensured people knew how to raise a complaint. One person told us, "I've told [registered manager], if I ever had anything to complain about I'd just call her." The provider had a complaints policy in place that was accessible to people. People were given information on how to raise a complaint and the provider also had a large print version available for people with visual impairments. We noted that at monthly surveys people were asked if they knew how to complain and this was also discussed at reviews. This ensured that people were given opportunities to raise any concerns or issues that they had. The provider had not received any complaints since our last inspection and all people that we spoke with told us that they had found no reason to raise a complaint.

Good

Is the service well-led?

Our findings

People told us that they got on well with the registered manager. One person said, "[Registered manager] is always popping in and out and seeing how things are." Another person said, "The manager is always around and things are always followed up."

The registered manager involved people in the running of the service. People told us that they were visited frequently by the registered manager and benefitted from regular phone calls. Records showed that each person had a monthly telephone survey as well as a review visit in which the registered manager attended and asked if they were happy with their care. Surveys were positive and people had expressed satisfaction with the care that they received. We saw that where issues were raised, these had been addressed. For example, one person had asked about mobility equipment and in response the registered manager had emailed the occupational therapist (OT) for an assessment.

Staff felt supported by management. One staff member said, "[Registered manager] is really on the ball. If we ever raise anything its sorted out straight away." Staff had regular opportunities to contribute to the running of the service. Regular staff meetings took place which were used to pass on important messages, as well as offer staff opportunities to make suggestions. We noted that the minutes of meetings were very detailed and used to improve quality of care. For example, a recent meeting had been used to discuss daily notes and that some improvements were required to ensure enough detail. We looked at daily notes and found that they were detailed and reflected people's daily care calls.

The provider carried out regular checks to assure the quality of the care that people received. As well as frequent surveys, the registered manager conducted monthly spot checks with staff. These involved observations of care, checking records, ensuring there was personal protective equipment (PPE) in place and testing staff knowledge. Records showed that spot checks were used to look at areas such as infection control, dignity, records and moving and handling. The registered also checked all daily notes and medicine administration records (MARs) each month. These were checked for any gaps and the examples we looked at were all complete. The registered manager told us that where they did identify gaps, staff were taken off medicine administration duties until they had attended refresher training and been signed off as competent to administer medicines again.

There were regular and ongoing improvements at the service. Before the inspection the provider completed a provider information return (PIR). In this document, the provider told us about any improvements that they planned to make. In their PIR, the provider told us that they would be introducing improvements to documentation and information provided to people. During the inspection, we found that the provider had implemented improvements to documentation. For example, the provider had introduced clearer care plan documentation that ensured people's needs, risks and preferences were clear for staff. There had also been improvements to staff files to ensure there were clear prompts for recruitment checks to be carried out. We found records were stored securely and in an organised manner with important information easy to identify.

The provider had developed links with the local community and relevant agencies. The registered manager

regularly attended forums such as the Surrey Care Association. This enabled the registered manager to discuss and share good practice with other local providers as well as provide access to training and advice. We saw records showing staff frequently worked alongside community healthcare professionals and the local authority. The feedback received from professionals prior to the inspection was all positive and one professional noted improvements to communication that had benefitted the care of one person.

The provider was aware of the responsibilities of their registration. Providers are required to notify CQC of important events such as deaths, serious injuries or allegations of abuse. We had not received any notifications in the last 12 months and we checked the provider's records which showed there had not been any significant events that required a notification to CQC. We discussed notifications with the registered manager and they demonstrated a good understanding of their responsibilities and when to notify CQC.