Homecare Alliance Limited

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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 service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. Homecare Alliance provides domiciliary care services to people living in the community in their own homes in one London borough. At the time of this inspection there were five people using the service including a child with special needs, a younger adult living with a disability and three older people. The service provider has links with community groups specifically supporting people from African communities and received referrals from local authorities who are seeking support from a provider that has knowledge of those communities. 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.

This was the first inspection of the service since initial registration in August 2017.

At the time of this inspection the registered provider also had the role of registered manager of the service and they were a director of the provider company. A registered manager is a person who has registered with the Care Quality Commission [CQC] 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 using the service had a care plan which contained information about the person and their care needs and requirements. As part of the care planning process, the registered manager carried out risk assessments which covered the home environment, personal care needs, moving and handling and health and safety.

Care workers were trained about how to identify types of abuse and there was clear guidance about the actions they should take if they had any concerns.

The registered manager had a sound knowledge of the Mental Capacity Act 2005 and how this could impact on the provision of care and support. Care plans demonstrated that mental capacity assessments took place and were acted upon.

Care workers received training in the safe administration of medicines. The registered manager monitored medicines recording and administration and there were systems in place to ensure this was managed safely.

The service had safe recruitment processes in place. These included obtaining references and the completion of a disclosure and barring service check prior to care workers commencing their employment. Care workers told us that they felt supported in their role and received regular supervision. None of the care workers had worked at the service for more than eight months.

Care workers, when they first started working at the service, received an in-house induction and training, which included safeguarding, moving and handling and medicine administration.

A spot check system was in place to monitor the care and support provided to people along with regular reviews of people's care and support needs. No missed visits had occurred and people were contacted if their care worker was delayed.

The service had a complaints policy which was given to people using the service and relatives. The registered manager reported that they had not received any complaints since the service began operating.

People were contacted regularly, which they confirmed, and were asked what they thought and the way the service operated day by day was monitored.

Further information is in the detailed findings below.

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. Care workers assessed people's individual risks associated with their care to mitigate or reduce risk to ensure people's safety.

Care workers were trained in keeping people safe from harm and they had to report any suspected signs of abuse to ensure people's safety.

Medicine administration was managed in a safe way. Medicine Administration Records listed the details of the medicines that were administered and who had provided that support.

Is the service effective?

Good

The service was effective. The registered provider and care workers considered mental capacity assessments to identify if any person lacked capacity. Action was taken to address any capacity concerns.

Care workers received an induction when they started work with the service that included shadowing with the provider.

People were pro-actively supported with their dietary and nutritional support needs by the service.

Is the service caring?

Good

The service was caring. People were treated with respect and care workers maintained privacy and dignity.

People were encouraged to have input into their care and their views were respected. We were informed by people using the service and relatives that care workers were kind and caring and paid attention to people.

Is the service responsive?

Good

The service was responsive. People's care needs were assessed and any changes to care needs were reviewed on a regular basis.

A complaints policy was available and was also given to people

and relatives when the service began. The service had not received any complaints.

Is the service well-led?

Good

The service was well led. The service had effective systems in place for monitoring the standard of day to day care.

The provider was also the registered manager of the service and was therefore fully aware of the way the service operated day to day. Audits were carried out regularly and the oversight of the service was operating well.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 6 August 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the registered provider would be present. The inspection was carried out by one inspector and an expert by experience that carried out telephone interviews with people using the service and relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at information that we had received about the service and any formal notifications that the service had sent to the CQC. We looked at four care records and risk assessments, five staff files, one medicine record and other documented information related to the management of the service. We spoke with the registered manager, we also received e-mail response from three of the five care workers that we contacted.

Good

Is the service safe?

Our findings

A person using the service told us, "I feel very safe because [care worker] understands my ways. I can talk with him because he speaks my language. Time of visiting is no problem."

The provider used a risk assessment process that held information for care workers about minimising risks to people receiving care. The registered manager was responsible for ensuring that each person using the service had a completed risk assessment, which included information about specific risks and minimising these risks. The action needed to reduce any potential harm due to these risks was identified and recorded. Care workers were provided with clear instructions about what to do to minimise potential risks.

One person received support with taking their medicines. Other people were helped by their family. A Medicine Administration Record (MAR) was held along with the person's care plan. The MAR charts described the medicines that were prescribed and the times they needed to be taken. The registered manager checked that medicines records were up to date and signed to confirm that they had reviewed the returned MAR charts and no issues had been identified on those we viewed. All care workers were trained in providing medicines support, although only one care worker had yet been required to assist with this. A relative had signed the consent on behalf of the person as the person was unable to physically sign but had full capacity to verbally confirm that they agreed to being assisted by care workers to take medicines.

A relative told us, "If, on the very rare occasions, that the carer can't come I arrange with the manager to be there with the replacement carer who has met [relative] before but isn't remembered by [relative]. She is less agitated and the manager understands that and works with me. Time keeping is very good and the manager rings if the carer is going to be even a few minutes late and we really appreciate that."

Care workers who replied to our request for feedback about the service told us, "Yes the service is safe" and "I am trained about keeping people safe." No concerns had arisen about possible abuse of people using the service. Training records showed that care workers received safeguarding training and as all care workers were relatively new the registered manager told us that this training would be updated when required, but no less than once a year. This was also stated in the providers training policy and dates by which refresher training was required were also listed.

The registered manager expected care workers to let them know if they were going to be late or unable to attend visits to people using the service. No missed visits had occurred.

Safe recruitment processes were used to ensure care workers were suitable to work with people. Recruitment files contained the necessary documentation including disclosure and barring checks, references and identity verification. Evidence was also available of care workers right to work in the UK if they were not UK nationals, which all care workers currently working with the service were.

All care workers were provided with personal protective equipment such as gloves and aprons that were supplied by the provider. We were informed that no-one using the service had any infectious diseases or

other conditions. Regardless of this all care workers were always required to use the protective equipment provided when carrying out personal care to minimise the risk of potential infection and maintain good hygiene standards.

The service had a system and guidance for care workers about reporting incidents, although we were informed that none had occurred. We verified that no notifications about serious events that might affect people's wellbeing had needed to be made to the commission.

Good

Is the service effective?

Our findings

A relative told us, "'The Manager comes to ask if we are happy or not happy. Sometimes she will bring an interpreter so she can hear from [relative]." Another relative told us, "The manager has given me good advice about equipment that would benefit my [relative]."

An initial assessment regarding people's care and support needs was carried out by the service before a package of care was agreed and provided. The service recorded individual personal details, information about people's health, medicines and care support. Environmental, health and safety and moving and handling risk assessments were also undertaken. Therefore, the agency could decide whether they would be able to meet the needs of the person. As a part of this assessment procedure the registered manager visited each person at their own home to talk with them and their family about their care and support needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lacked mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this was in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). Deprivation of liberty safeguards do not apply in a service of this kind. We checked whether the service was working within the principles of the MCA. The registered manager undertook mental capacity assessments when people were first referred to the service.

One person using the service had been assessed as lacking capacity, and the appropriate power of attorney process for a relative to legally provide consent had been undertaken. Another person using the service was a small child so consent had been obtained from their parents.

A care worker told us, "Yes, I have done safeguarding and medication training. Yes, the services I provided is what is in care plan. My manager told me that I will be doing soon a child protection training also. I am doing the care certificate at the end of this year." Another care worker said, "Yes, I have been trained about providing care and support, I will be completing my Care Certificate in November."

In-house induction was provided to all new care workers. The registered manager informed us that they were in the process of securing a training package to ensure that all care workers enrolled on and completed the care certificate. We were shown information that the registered manager had obtained about this. The Care Certificate is a set of standards that new health and social care workers follow at the start of their professional duties. As part of the induction all internal procedures of the service, which included key policies and the day to day procedures about working for the agency were included. Induction also covered medicines, safeguarding adults and children, health and safety, food hygiene and hygiene.

The service had a supervision policy, which stipulated that care workers would receive supervision every

three months. Almost all care workers were within the six-month probationary period when supervision was more frequent. The provider's policy about the frequency of supervision during staff induction was being followed by the registered manager. Care workers records showed that they were involved in supervision sessions and other regular communication with the agency. This demonstrated that the registered manager was using systems to offer care workers the support they required to do their work.

The service provided meal preparation for people where this was required. This included heating up food prepared by the person's own family, preparing a meal or making a snack such as sandwiches. All care workers had been trained in food hygiene and people's preferences for meals, snacks and drinks were recorded in their care plan if care workers assisted them with this.

Care plans compiled by the registered manager included information about people's physical and healthcare conditions. As an example, a child lived with very complex healthcare needs and the service had worked well with the family and provided training and guidance to the care workers that supported the child. Care workers did not usually attend healthcare appointments with people as this was managed by people themselves with assistance from their family as needed, but care workers would assist if an urgent request to help was received. The registered manager told us that they were the point of contact for all care workers if an emergency arose and could always be contacted by telephone. We were informed by the registered manager that no emergency situations had arisen but care workers did make contact about day to day matters as these arose.

Good

Is the service caring?

Our findings

A relative told us, "[Relative] doesn't speak English and she has been well placed with a care worker who speaks her language and understands [relative's] customs." Another relative told us that their relative, "Is happy and I'm happy. The care worker is very respectful, she speaks the same language and knows how to look after [relative]."

Relatives were consulted about care assessments and care plans with the permission of the people receiving care. This involvement was recorded on assessments and care plans as often relatives might be present when these discussions were held.

One care worker told us, "I think there is a good relationship between the agency and clients, and clients talk about the agency in a positive way. and the manager visits them." Another care worker told us, "The agency always answers their phone when I call to ask about anything no matter what time it is and make sure everything is fine."

The provider gave clear information and guidance to care workers and trained them to provide dignified and considerate care. Planning the care of people took account of the whole person and their emotional as well as their physical care needs.

The provider had clear policies in relation to the right of people to have their diversity and protected characteristics, for example due to disability, respected. Care workers were matched to the people they supported. As far as possible, and this was entirely the case, care workers were matched to the person based on their own experience of the person's cultural background and preferred language and care workers had a range of language skills.

The provider had links with community groups which supported people from different African communities, most specifically at present from Somalia. The provider was familiar, as too were care staff, about the support needs and expectations about how care and support should be provided for people from this community.

Good

Is the service responsive?

Our findings

A person using the service told us, "I call the manager lots and it's never a trouble. She has helped me with filling in forms and it's a very good company." Another relative said, "Two care workers come and they talk easily with [relative] and joke, my relative is very comfortable with them. They help in ways my relative knows best and they write notes in the log book."

Each care plan was written when the person first started to use the service. We found that each person's care needs had been fully described, life history was included and detailed care notes were kept. These notes were written on a specific log that had been designed by the provider. Once completed, these log books were returned to the agency office to be kept along with other care records. A sample of the completed and returned logs books we seen during our inspection, which were signed by the registered manager to confirm they had been seen and the quality of the notes had been reviewed. The notes log book outlined the tasks that people were supported with and allowed care workers to add further notes about specific support and the engagement they had with each person. This was a clear method of recording and provided more than suitable information about the care and support that had been provided to each person. This ensured that care workers had the most recent information to respond and meet each person's current care and support needs.

A care worker told us, "The agency respect client's cultural needs by assigning care workers who know and have the same cultural beliefs." Another care worker said, "I find the agency is accessible to me and the people using the service. The clients can call the agency about any issues and the agency resolve it."
The provider's complaints policy was given to people and relatives when the service was provided. The policy described how to raise a complaint and the time frames in which the complaint would be dealt with by the provider. We looked at the complaints record and found that the service had not received any complaints since registration with the CQC. People told us they knew who to contact if they wanted to raise any concern.

The service did not specialise in providing end of life care, however, there was a detailed policy and guidance for care workers about what was expected should anyone using the service in future require this support.

Good

Is the service well-led?

Our findings

A relative told us, "In the past we have had agencies where I am always being called away from work because of a problem with the carer, but with this agency that never happens and I can relax and get on with my work."

The registered manager had the appropriate training and many years of direct professional experience of working in social care.

The service provided care and support that was of a good standard and people were happy with it, and evidently felt able to approach the registered manager if they were not happy.

Care workers told us, "I call the agency when I need they always answer the telephone if they do not answer at the time they call me back, I think the service is running well in my opinion." Another care worker said, "I call the agency any time I need them and they answer the phone. The manager is always on hand to offer support."

The service had a rota management system, which was used to plan and organise each care workers visits to people. Usually care workers worked specifically with one or two people at set times each day of the week. We looked at this system for the last three months and found that it was well managed and if any changes were needed due to unforeseen circumstances this was responded to. Care workers were assigned to cover specific people's visits throughout each week and this system was working well.

There were systems in place to monitor the service. For example, the registered manager carried out audits across a range of areas. These included spot checks either in person and by telephone contact, monitoring care workers training and care workers performance. There were also systems in place for regular reviews of day to day care needs and audits of care plans, risk assessments and medicines management all took place.

The provider currently provided a service to people whose care was funded by local authorities. The provider had already carried out informal consultation with people using the service and relatives. A formal process was being established, however, it was evident from what people told us that regular contact was maintained and people's views were sought even though the service was still new. This demonstrated a positive commitment by the provider to consult with people.

The service had appropriate, up to date policies and procedures in place, which were available to care workers to guide on various areas of their work. For example, the policies included hygiene and infection control, safeguarding people from abuse, equality and diversity, medicines management and complaints. The provider was registered with the office of the information commissioner and had a detailed policy and procedure in place for management of personal data and information sharing.