Alina Homecare Ltd

Alina Homecare Poole

Inspection report

Unit 4
Concept Park, Innovation Close
Poole
Dorset
BH12 4QT

Tel: 01202816146
Website: www.alinahomecare.com

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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

Alina Homecare Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats. Alina Homecare Limited provided this service to 47 adults at the time of this inspection.

This announced inspection took place on the 30 April 2018 and 2 and 4 May 2018. There was a registered manager for the service. 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.

Staff understood the risks people faced and how to reduce these risks. Measures to reduce risk reflected people's wishes and preferences. Staff also knew how to identify and respond to abuse and told us they would whistleblow if it was necessary.

Staff encouraged people to make decisions about their lives. However, care plans did not always reflect the care that was being delivered or how it was developed within the framework of the Mental Capacity Act 2005. This was addressed during our inspection.

People were supported by safely recruited staff who were committed, kind and enthusiastic. Staff told us they felt supported in their roles and had taken training that provided them with some of the necessary knowledge and skills. People told us that staff were usually on time and they were mostly told if their visit would be late.

Oversight structures and ethos of care were clearly communicated and the quality assurance systems had been effective in identifying areas for improvement. People and relatives mostly felt that they were listened to and we saw that their views informed improvement work.

There were systems in place to ensure people had enough to eat and drink and that people were supported safely when eating and drinking.

People were positive about the care they received from the service and told us the staff were kind. Staff were cheerful and treated people with respect and kindness throughout our inspection.

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 usually safe. People's medicines were not always administered safely. This was addressed immediately during our inspection,

People were supported by staff who had been recruited safely and had the necessary skills and knowledge to support them.

People were supported by staff who understood how to reduce the risks people faced. Staff understood how to protect people from abuse.

Is the service effective?

Good

The service was effective. Staff had the knowledge necessary to deliver effective care.

Staff had a good understanding of the principles of the MCA and incorporated these in their work. Records did not always reflect the framework of the MCA. This was addressed during our inspection.

People, or those who knew them well, were involved in the assessment of their care needs and care planning. This meant their preferences were reflected in their care plans.

Is the service caring?

Good

The service was caring.

People received support from staff who cared about them and liked and respected them. Staff developed relationships with people and took the time to get to know them individually.

People and their relatives were listened to and felt involved in making decisions about their day to day care.

Is the service responsive?

Good

The service was responsive. People received the support they needed.

People and their relatives were mostly confident they were listened to and knew how to complain if they felt it necessary.

Is the service well-led?

Good

The service was well led.

There were systems in place to monitor and improve quality including seeking the views of people, their relatives and staff These had been effective in making improvements to the quality of care and support people received.

The provider organisation was committed to involving staff in work designed to improve quality in the experience of staff and people using the service.

Alina Homecare Poole

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 the 30 April 2018 and 2 and 4 May 2018 and was announced. We announced this inspection to ensure people could be contacted and asked to take part in our inspection. The inspection team was made up of one inspector, an assistant 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.

Before the inspection we reviewed information we held about the service. This included notifications the service had sent us and information received from other parties. We also reviewed the Provider Information Return (PIR). 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. We had asked for this information in July 2017 and were able to gather relevant up to date information during our inspection.

During our inspection we visited two people receiving care and spoke with a further four people and two relatives of people who used the service. We spoke with seven care workers, the training and quality managers from the provider organisation and the registered manager. We looked at seven people's care records and medicines administration records. We also reviewed records relating to the running of the service. This included five staff records, quality monitoring audits and accident and incident records.

We also spoke with or received feedback from social care professionals and commissioners who worked with the service.

Good

Is the service safe?

Our findings

People and relatives told us they felt safe with the staff. One person said: "They help me to stay safe." And another person told us "I always feel safe with them." Risk assessments were reviewed regularly and took into account people's views and preferences. Staff understood the risks people faced and were able to confidently describe the measures in place to address these. For example, staff had a very clear understanding about the measures in place to protect people's skin and how they reduced the risk of people falling in between care visits.

There were procedures in place to support good safeguarding practice. Staff were able to describe signs of abuse and had received training in how to follow the safeguarding process. They told us how they would report any suspected abuse and were confident concerns would be taken seriously by managers. One member of staff told us: "I would report it to the office straight away. If I still had concerns I could call safeguarding." Staff all had access to the telephone number for the safeguarding authority.

Staffing deployment reflected the needs of people and rosters were being reviewed at the time of our inspection. Some staff commented that the new rosters did not deploy them effectively and we highlighted this to the registered manager. The registered manager had identified this prior to our inspection and was taking steps to address this. There were enough staff to meet people's needs however visits had been missed on 3 days since the start of 2018. These had been fully investigated and actions taken as appropriate. People told us that staff usually arrived on time and they were mostly told if a visit would be late.

Staff understood their responsibilities to ensure infection control was effectively managed and we were told by most people that they used gloves and aprons appropriately.

Health and safety procedures were operated and these were reviewed within the quality assurance framework. This meant that equipment used by staff in people's homes was suitably maintained. Staff checked equipment before they used it and liaised with health professionals and others to ensure equipment was replaced and serviced appropriately. There were systems in place to reduce the risks to staff inherent in lone community based working. The registered manager highlighted how the risks associated with working in specific environments were considered.

Staff who supported people with their medicines had undertaken training and had their competency assessed. The administration of time dependent medicines was not robust. This was because care plans were not always clear about when medicines should be given and staff had not recorded an exact time of administration. This meant it was not possible to tell when people had received their medicines. We spoke with the registered manager about this and they altered care plans immediately to reflect this and identified how new paperwork that was being implemented for medicines would address the recording of times.

Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and to report these. Accident and incident reports were reviewed and actions taken as necessary. Staff were encouraged to flag mistakes and an ethos of learning was described by posters on the wall in the office.

Good

Is the service effective?

Our findings

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 people lack mental capacity to take particular decisions, any decisions 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. We were told that two people lacked capacity to consent to their care by the registered manager. A senior member of staff who had undertaken their care planning told us they could say if they did not want care but did not understand the impact of this. Their care plans did not reflect that an assessment of capacity had been undertaken as outlined by the MCA and best interests decisions were not recorded. We spoke with the registered manager and quality lead for the provider about this. They identified the appropriate paper work and initiated the necessary MCA assessments and planned for best interests decisions. Whilst this increased the risks of people not receiving the least restrictive care possible, staff had received training in the MCA and all spoke passionately about promoting people's choices and ensuring their care was provided in the least restrictive way. They were confident in how they should respond respectfully and appropriately when people declined care. People who were able to provide consent felt this was sought. One person told us: "They check with me before they do anything."

People, and those who knew them well, were involved in developing their care plans following an assessment process. This meant that people's care plans reflected the outcomes that mattered to them, including outcomes reflecting social and community needs, and ensured that their preferences were met. Detail about people's history and preferences ensured that staff spoke with confidence about the details that ensured individual and effective care for people.

Assessments and the resultant care plans were written with respect and promoted people's human rights. This translated into the way staff spoke about people with respect and without judgement. This meant people were protected from discrimination on the grounds of their gender, race, sexuality, disability or age.

Where health professionals, such as occupational therapists, had assessed a person this information was incorporated into the service care plan for the person. This ensured that care was delivered in a way that reflected current good practice.

People told us that staff had the skills required to support them as they needed. One person had written to the service highlighting how "excellent" and "efficient" staff were. One person told us the staff had the "right training."

Records showed staff undertook regular training to enable them to carry out their roles. This training was comprehensive and up to date. Some people had specialist care needs that were not reflected robustly in the mandatory training. For example, staff who supported people who used catheters had received

additional training. This had not been recorded however staff verified they had attended We discussed specialist training such as epilepsy with the training manager. They told us this was available to staff when needed. We noted that one member of staff, who worked with a person who had seizures, had not undertaken epilepsy training. This was addressed before we completed our inspection.

Some of the staff who had recently joined the team were new to care work and had started the Care Certificate. The Care Certificate is designed to help ensure care staff that are new to working in care have initial training that gives them an understanding of good working practice within the care sector. Staff also learned about people's needs through a shadowing period and by working alongside more experienced staff. The competency of staff was checked before they worked alone and through regular spot checks on their practice.

Staff told us they felt supported by their colleagues. They acknowledged that they had been through an unsettled time with management changes but commented on how they were all working hard to secure the team. One member of staff reflected on the support of the whole staff team saying: "It is a really good team." Another member of staff commented: "If I have any concerns I can just come in (to the office) and ask." Staff took part in regular supervision and appraisal sessions. This gave them an opportunity to discuss any concerns, reflect on how their values impacted on their work, highlight any training needs and discuss their career.

People were supported with their day to day health needs in conjunction with health care professionals. Records showed that people had regular contact from a range of health professionals such as: occupational therapists, district nurses and speech and language therapists.

Where people were supported by care staff to eat and drink they were involved in decisions about this. This meant that any dietary, cultural or religious needs were respected. People were encouraged to have a balanced diet that supported their health and well-being whilst respecting their rights to make unwise decisions. There were systems in place to ensure safe swallow plans drawn up by a speech therapist and one person had guidance in place that staff all understood and followed.

Good

Is the service caring?

Our findings

Relatives and people liked the staff and made comments such as: "All the carers are happy and helpful and lovely to my (loved one)", "The carers worry about us. They are very good", "wonderful carers" and "a joy to have". People and relatives highlighted the importance of laughter in people's days and often described the interaction that they had with care staff in these terms. Some people highlighted that staff were sometimes not guarded about confidentiality or their own moods and this led to difficult feelings for the people. We spoke with the registered manager about this and they addressed it immediately.

Kindness, compassion and an enthusiasm to ensure a caring service were evident across the staff team who described people in very positive ways. One member of care staff told us:"(person) is one of the nicest people you could meet." Another member of staff said: "They (a person they had just provided care for) are lovely." People could not all use words effectively to tell us their views of the staff however we saw they responded positively to them. A member of staff reflected on how they respected a person who no longer used words to communicate. They told us "We talk to (person the whole time. We reassure. We explain." Relatives, and staff, told us that people were also able to express without words when they were not happy with something and this was 'listened to' and action taken.

Whilst attentive the staff also respected people's space and autonomy within their homes. One member of staff said: "I do care. I like to help keep people at home. Their home, their rules, their terms – it is where they want to be –it's about making sure they are happy and safe."

Staff were not rushed and described the parts of daily life people could undertake themselves. They were supported by care plans that promoted independence and reinforced people's human rights. They also sometimes had time to carry out tasks that people described as 'over and above' for example one person told us how they had done some dishes for them and they said : "I thought that was really kind of them."

Good

Is the service responsive?

Our findings

People were positive about the care staff who visited making comments such as: "pretty much the same carers that come. They are all smiley and sweet". Comments about communication with the office reflected a more mixed experience. Most people referred to these staff as "helpful" and "kind" some people commented that agreed changes had not been made and they had needed to repeat their requests.

Staff described people's needs consistently and confidently; emphasising people's strengths and individuality in all their discussion with us. Care plans had been reviewed and covered a range of areas including personal care, mobility, and communication. They were personalised and contained information about people's likes and dislikes and referred to people who were important in their lives.. Staff were aware of each person's care plan and had the opportunity to read these and highlight when change was needed.

Communication needs were identified and recorded within the care plans with information provided to support staff. For example, one person's care plan stated: "(Person's name) sometimes needs time to process what you are asking (them). Please give (them) time to make (their) decision." Another person's care plan stated: "I can communicate with yes or no answers."

There was a system in place for receiving and investigating complaints. People and relatives confirmed they knew how to make a complaint and felt any concerns raised would be dealt with. Where learning from complaints was identified, it was clear that action had been taken. For example, a complaint had led to increased supervisions and spot checks for care staff. A number of compliments had then been received reflecting a positive outcome for staff and people alike.

At the time of our inspection no one was having end of life care. The registered manager described the way they had previously provided this support to people. End of life care was discussed with people and their relatives to ensure their wishes were respected. Some staff had been identified as particularly skilled at supporting people and their loved ones during this time and they had received training to support them in this role. Compliments had been received from families expressing their appreciation of care provided when loved ones had died.

People were invited to the office to meet each other and staff and the registered manager was eager to promote a sense of community for people who wished to take part. People had been invited to a party to celebrate the Queen's birthday and to attend a baby shower prior to the registered manager's maternity leave. Transport had been arranged to help people take part after this was identified as difficult for some people. The registered manager confirmed that more events were planned.

Good

Is the service well-led?

Our findings

The provider's mission to "make life easier for people by providing excellent care services and by valuing and respecting our staff" was reflected in the way the service was led. A staff forum was run by the director of operations on a six-monthly basis. This reflected the commitment of senior managers to the well being of staff.

The registered manager spoke highly of the staff team and told us they were all motivated to do the best for people. They told us "I want good carers and I want them to stay. I want them to be looked after." They spoke with pride, and affection, about a team that they described as "caring, passionate, strong willed, listeners and questioners."

The care staff also spoke highly of each other and were confident that all their colleagues always had people's best interests at heart. One member of staff said: "All the other carers are lovely." Staff spoke with pride about their own work and with respect for the rest of the team in ensuring good outcomes for people. One member of the office team said: "All of us do our jobs to the best of our abilities and with (registered manager)'s support it will get better and better." Staff commented on the availability of the registered manager and felt confident they could come into the office or call with any concerns. This openness was being supported by regular Friday slots when staff were encouraged to call into the office and spend time with the registered manager and other care staff with the aim of supporting positive and effective working relationships.

The registered provider had a quality assurance process that included regular visits to the service. The registered manager and senior staff also undertook audits. These had been effective in improving the quality of the service people received. For example, medicine timing errors had been identified and a new recording system was being implemented. Where training or awareness issues were identified by audits there was a clear follow up with individual staff or the team as a whole as appropriate. Feedback from staff was also used to inform improvements and we were reassured that all deployment issues raised in our discussions with staff were being addressed by the registered manager before we highlighted them. People's feedback was gathered and action plans developed from the results. Team meeting minutes reflected that staff were involved in discussions about how to improve the service. The registered manager told us they believed it was important that staff understood they had control over improving the service.
When compliments were received or staff needed commendation this was also shared and reported in a regular newsletter to the staff team.

Alongside robust monitoring systems, the quality assurance process included quarterly provider level quality committee. Care staff from Alina Home Care Ltd were represented at this meeting. This reflected an approach to quality that respected the knowledge and skills of frontline care staff. Staff were supported to embrace change and take responsibility for their role in it. An electronic call monitoring system had been introduced by the provider to support staff safety and improve the quality of service received by people. The registered manager had worked to encourage staff to engage with this new system, ensuring they understood the benefits. They told us that the data it provided would be invaluable in improving rostering

for staff and people alike.

Learning was shared across the provider organisation and this led to positive outcomes for people. For example, learning from snowy weather in another part of the country had been disseminated. When bad weather struck the Poole service they were well prepared and this led to a clearly communicated and effectively delivered response. On member of staff told us: "We worked together. Carers went out walking. It was good communication."

The provider was trialling an electronic care planning and recording system and there were plans to start using this system in Poole once the 3 month trial had been reviewed. This meant that problems with the system would be addressed before it was introduced across the whole provider enabling support and adaptation during the staged rollout.

The management was responsive to the input of other professionals. We saw that improvements identified by the local authority had been actioned and the quality lead and registered manager responded fast to all opportunities to develop the quality of the service identified through the inspection process.

The provider organisation understood their legal responsibilities and the registered persons had ensured relevant legal requirements, including registration and safety related obligations had been complied with.

There was a clear structure within the service with staff understanding each other's roles. The registered manager highlighted that the provider organisation valued the staff and ensured that there were roles such as care ambassador available for them to progress into. Care ambassadors took on a number of roles such as a mentoring new staff. We spoke with a member of staff who described how important this role was.

Records were stored tidily and securely and there were systems in place to ensure data security breaches were minimised. Staff had log ons to access computer based records and records were locked away when not in use. Some records had not been brought into the office from a person's home. The registered manager acknowledged this and arranged to have them collected.