All Star Care Limited

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Inspection report

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Date of inspection visit:
23 April 2018

Date of publication:
02 July 2018

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. All Star Care provides domiciliary care services to people living in the community in their own homes in two London boroughs. At the time of this inspection there were four people using the service. The service provides personal care to older 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.

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

At the time of this inspection there was a registered manager in post. 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 staff 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 and care staff had a good understanding 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 staff 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 the care staff commencing their employment. Care staff told us that they felt supported in their role and received regular supervision. Most care staff had been working at the service for under a year. Annual appraisals had not yet been completed yet, apart from one for a longer serving member of care staff. The registered manager told us this would occur for the remaining staff before their first anniversary of starting work at the agency.

Care staff, 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.

Although the service was relatively new, quality assurance questionnaires had been completed. These showed a high degree of satisfaction with the service by people using it and their relatives. There was regular contact with people by the registered manager.

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

Care staff 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.

Is the service effective?

Good

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

Care staff received an induction when they started work with the service that included shadowing of more experienced staff.

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 staff 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 staff were kind and caring and paid attention to people.

Is the service responsive?

Good

The service was responsive. People's care needs were assessed prior to them receiving care and 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 registered manager was able to show us how they sought people's views and checks they had in place to keep the quality of the service under review.

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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 23 April 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the registered manager 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 three care records and risk assessments, five staff files, a medicine record and other documented information related to the management of the service. We spoke with the registered manager, a care worker and received an e-mail response from two other care staff that we contacted.

During our inspection we spoke with one person using the service and two relatives of other people using the service.

Good

Is the service safe?

Our findings

Relatives spoke with us about how safe they thought the service was. They told us "We feel our relative is very safe; we are informed if anything is wrong or needs doing; the carers are very good", "My relative is much safer with this agency which makes me feel more relaxed" and "My relative can't be left alone. If I am late getting home the carer will stay with him until we arrive."

The provider used a risk assessment process that held information for care staff 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 staff were provided with clear instructions about what to do to minimise potential risks. However, in one instance we found two reviews of falls risk assessments for a person and neither had been dated. The procedure was for at least an annual risk assessment reviews and the person had been using the service for six months. The risk was low, however, we raised this with the manager to ensure that dates were included in all cases, although this was not an issue on the other risk assessments we reviewed.

One person received support with taking their medicines. Other people were helped by their family. The registered manager provided the support for this person. 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. All care staff were trained in providing medicines support, although only the registered manager had yet been required to assist with this. A relative that had lasting power of attorney, had signed consent on behalf of the person to confirm that they agreed to being assisted by staff to take medicines.

Care staff who replied to our request for feedback about the service told us, "All Star Care is the safest place I have worked to date. The registered manager speaks to me every day to ensure that clients are ok and to discuss any concerns I may have." We were also told "I am trained about to report concerns about abuse to management. If nothing was done by the management team then it is my responsibility to report and concerns about abuse to social services." No concerns had arisen about possible abuse of people using the service. Training records showed that care staff received safeguarding training and as all staff were relatively new the registered manager told us that this training would be updated when required, but no less than once a year.

The registered manager expected staff to let them know if they were going to be late or unable to attend visits to people using the service. No missed or late visits had occurred and no one we spoke with told us of any missed or late visits.

Safe recruitment processes were used to ensure staff 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 staff member's right to work in the UK if they were not UK nationals. Where this was required the provider had completed the checklist which the home office advised

employers to use to correctly verify staff eligibility to work in the UK.

All staff 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 staff were always required to use the protective equipment provided when carrying out intimate physical care to minimise the risk of potential infection and maintain good hygiene standards.

The service had a system and guidance for staff about reporting incidents, although we were informed that none had occurred and we verified that no notifications had needed to be made to the commission.

Good

Is the service effective?

Our findings

A person using the service told us "I like everything about my carers. They shower me every day and I am very happy how they do it." Other people said, "They put the food on a spoon and encourage me to eat it which is good as otherwise I would not eat" and "The carers ask me what I want to eat."

A relative told us, "Due to dementia our relative can get difficult. The carers take the trouble to explain the benefit of what they want her to do and keep repeating it if necessary. If she needs directing somewhere they will gently steer and help her. If she becomes too challenging they will leave her to settle down."

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 who was referred 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). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS), however, DoLS does 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.

Two people using the service had been assessed as lacking capacity, and the appropriate power of attorney process for relatives to legally provide consent had been undertaken.

Members of the care staff team who contacted us said, "I was given five days induction training about many different areas of care. This included moving and handling and training about how to use a hoist." We were also told "I had one week's training to prior to starting my role then booked on a 12 weeks training course, which was very informative. My induction was good, I had a week induction with just training, then another week of shadowing and meeting the service user."

In-house induction was provided to all new care staff in line with the Care Certificate. The Care Certificate is a set of standards that new health and social care staff follow when at the start of their professional duties.

The service had been registered with Skills for Care, which is a nationally recognised training body funded by government. 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. All staff had achieved the Care Certificate.

A member of the care staff team who responded to us about their supervision said, "Supervision is done formally once a month but the manager speaks to me every day to ensure everything is fine." The service had a supervision policy, which stipulated that care staff would receive supervision every three months. This average was being maintained for the longer serving members of care staff and was more frequent for newer staff. Staff records showed that staff were involved in supervision sessions and other regular communication with the agency. This demonstrated that the registered manager was using systems to offer staff the support they required to do their work.

Relative's told us "If we forget to have a meal ready the carers will sort out what to do", "The carers will cook a fresh meal for our relative" and "Our relative was not drinking enough so the carers encourage her to do so."

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 staff had been trained in food hygiene and people's preferences for meals, snacks and drinks were recorded in their care plan.

Care plans compiled by the registered manager included information about people's physical and healthcare conditions. Care staff did not routinely attend healthcare appointments with people as this was managed by people themselves with assistance from their family as needed, but staff would assist if an urgent request to help was received. The registered manager told us that they were the point of contact for all staff 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 staff did make contact about day to day matters as these arose. Staff who we had contact with confirmed these arrangements.

Good

Is the service caring?

Our findings

A person using the service told us ""I like everything about my carers, I love them like my children. I sometimes cry when they go because I like them so much. I would not like a change of carers."

Relatives told us, "The carers are very professional, they respect the ways of older people. They don't force her to do anything, they just prompt her which usually works" and "My relative has trouble interacting with people but he is very comfortable with the carer."

The service was clear about obtaining consent to care and had done so in each of the care plans that we viewed. Apart from two people, whose relative's had legal power of attorney to provide consent, the other people had each consented themselves to their care and had not required anyone else to do so for them. 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.

A member of care staff team told us, "The service is very caring. As part of the induction I was trained on how to respect people's privacy and dignity. For instance, when giving personal care to the client. We ask them for consent if they are able to and read their care plans and ensure that the curtains are closed, the client is covered and that you speak to them and explain clearly what you are doing." Another member of care staff told us "We are trained that every client is an individual who wants to be treated with respect. My first strategy is developing a relationship first, to read the care plan and to know each client's needs. I can give the best support because I will understand their needs."

The provider gave clear information and guidance to care staff 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.

A member of the care staff team told us "At All Star Care there is an equality and diversity policy and procedure that guides us as carers. There is a full awareness of the legal framework for equality and I am also updated about any changes to policies and procedure." We were also told "We are given training around meeting people's cultural and diverse needs and to be aware of their different cultural practises as much as possible. At present I care for an Asian man, whose wife speaks limited English. Prior to visiting the family my manager and I create a chart with the different phrases that the wife speaks in Urdu and Punjabi to ensure that I can have some level of communication with her. My manager speaks to the family every day to enquire about the care they are receiving and no complaint to date." The agency did not have any current staff who could speak the relative's first language but had made efforts to try to overcome the language difference, however, staff were able to communicate with the person that was using the service.

A relative told us "The carers talk to our relative about the old times in her country of origin; they also play her music and cook her food from there. The agency tries to match the carers from the same culture."

The provider had clear policies in relation to the right of people to have their diverse characteristics respected. Care staff were matched to the people they supported. As far as possible, and this was almost entirely the case, staff were matched to the person based on their own experience of the person's cultural background. Where one member of care staff provided support to a person where this match was not possible for all visits they received, consideration had been given to this. This consideration included the care staff ability to acknowledge and respect the person, and their family's heritage.

Good

Is the service responsive?

Our findings

A person using the service told us "I used to like dancing; sometimes the carers will dance for me and I give them a hug" and "I would complain but I have never had to."

A relative told us "They are very flexible about visit times when required. If I have to take my relative out they will get there early to have her ready." Others said "The care plan was reviewed a couple of weeks ago. I was present and had a good input. The visit report book seems accurate" and "The care plan is very good." 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 CQC. People told us they knew who to contact if they wanted to raise any concern.

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 in a specific log book 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. The completed and returned log books we seen during our inspection. The notes log book outlined the tasks that people were supported with and allowed care staff 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 staff had the most recent information to respond and meet each person's current care and support needs.

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

Good

Is the service well-led?

Our findings

At the time of our inspection, the service had a registered manager. The registered manager had appropriate training and experience to manage the regulated activity.
A person using the service told us" "Nothing could be done better."

Relative's told us that "My relative has improved a lot so her care must have improved since we have been using the agency", "This agency listens to me and we communicate very well" and "I am fully satisfied with the service. My relative is very happy and does not want anything to change. I recommend them [the provider] to other people."

Relatives went on to tell us "I am assured by the service and I am more relaxed as I know she is being cared for. A good point is that she only has two regular carers" and "They make sure there is no more than three regular carers. With our previous agency we had fifteen in one month! The carers stay their full allocated time."
The service provided care and support that was of a good standard and people were happy with it, and evidently felt able to raise concerns if they were not happy.
Care staff told us "I am on a weekly rota with my clients. I am able to contact the management team at the office phone or by mobile phone" and "She [the registered manager] is the best manager ever she is down to earth and easily accessible.

The service had a rota management system, which was used to plan and organise each staff member's visits to people. 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. Staff were assigned to cover specific people's care needs throughout each week and this system was working well.

There were systems in place to monitor the service. For example, the manager carried out audits across a range of areas. These included spot checks either in person or by telephone contact, monitoring staff training and staff performance. There were also systems in place for regular review 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. We looked at the feedback that had been received and there was a consistent theme that people thought the service operated well and cared for people. It was too early in the operation of the service for an annual quality assurance process to be undertaken. It was, however, evident that continued contact was maintained with people and their views were sought. Peoples views were gathered during spot checks and these views were recorded.

The service had appropriate, up to date policies and procedures in place, which were available to staff to guide on various areas of their work. The policies included hygiene and infection control, safeguarding people from abuse, equality and diversity, medicines management and complaints.