Inspection Report 2023-2024

Able Homecare

Domiciliary Care

14 March 2024

Isle of Man Government

DHSC

Under the Regulation of Care Act 2013 and Regulation of Care (Care Services) Regulations 2013

SECTION A Overall Summary

We carried out this inspection under Part 4 of the Regulation of Care Act 2013 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements, regulations and standards associated with the Act. We looked at the overall quality of the service.

We carried out this announced inspection on the 14 March 2024. The inspection was led by an inspector from the Registration and Inspection team.

Service and service type
Able Homecare is a privately owned domiciliary care agency. The service arranges for others to be provided with personal care and support, with or without practical assistance, to those in their own private dwelling across the North, East and West of the Isle of Man.

People's experience of using this service and what we found

To get to the heart of people's experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our key findings
We identified areas for improvement in relation to the safeguarding policy, risk management, staffing rotas, policies and procedures, staff training and the statement of purpose and notifying the Registration and Inspection team of incidents.

Staff understood their responsibilities to raise concerns and report them internally and externally. Incidents were reviewed to reduce the risk of occurrence.

Staff sought guidance from other professionals to ensure the clients' day-to-day health and wellbeing needs were met.

Staff knew the clients and their needs well. Staff ensured that the care they provide protects the clients' privacy and respects their choices and rights.

Staff supported people to maintain relationships with people that matter to them.

Staff spoke positively about the management team and felt supported, respected and valued.

At this inspection, we found that areas for improvement from the previous inspection had been met.

SECTION B The Inspection

About the service
Able Homecare is registered as a domiciliary care agency set up to deliver care and support to people who live in their own homes across the North, East and West of the Isle of Man. The service is operated from a premises located in Lezayre, Ramsey.

Registered manager status
The service does not have a registered manager. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of Inspection
This inspection was part of our annual inspection programme, which took place between April 2023 and March 2024.

Inspection activity started on 8 March 2024. We visited the location's office on 14 March 2024 and received further information to conclude the inspection process on the 19 March 2024.

What we did before the inspection
We reviewed information we received about the service since the last inspection. We used the information the provider sent us in the Provider Information Return (PIR). This contained information about their service, what they do well, and improvements they plan to make. We reviewed notification of events, complaints, compliments and any safeguarding issues. The inspector also reviewed a number of policies and procedures.

During the inspection
We reviewed a range of records. This included peoples care records and a variety of records relating to the management of the service, including staff recruitment records, the provider's quality assurance information, staff supervisions, team meetings. We spoke with the deputy manager throughout the inspection and fed back to the responsible person and deputy manager at the end of the inspection.

After the inspection
We spoke to one person receiving a service about their experiences of the service provider. We spoke with two family members of people receiving a service about their experiences of the service provider.

We received feedback from four members of staff, who told us about their experiences of providing care and working with the manager.

SECTION C Inspection Findings

C1 Is the service safe?

Our findings:
Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. The service does require improvements in this area.

This service was found not to be safe in line with the inspection framework.

Systems and processes to safeguard people from the risk of abuse
The provider had systems and processes in place to safeguard people from abuse and harm; however, their safeguarding policy and procedure required updating to include information that reflects the Isle of Man multiagency policy and procedures. The provider's policy refers to a number of types of abuse, which were not acknowledged forms of abuse. Categories of abuse must reflect statutory guidance.

There was no evidence to support that two staff members had received training in safeguarding. This will be an area for improvement under the 'Responsive' domain.

The provider had a register to record accidents, incidents and safeguarding concerns. The deputy manager informed us they used information from any incidents or accidents to identify trends, which led to developing areas for improvement to keep people safe from harm.

The responsible person or the deputy manager had not submitted notifications of all significant events to the Registration and Inspection team in line with regulatory requirements. This is an area for improvement under the 'Well Led' domain.

Staff members assured us they knew what to do to safeguard the clients they cared for and would report any concerns to the responsible person or the deputy manager.

People receiving a service told us they felt safe with the caring staff and if they had any concerns, they would speak to the responsible person and/or the deputy manager. People felt confident that the management team would take their concerns seriously and address them.

Assessing risk, safety monitoring and management
The provider had completed an assessment prior to the person receiving a service. The provider used this assessment, supplemented by other information from the client's family and/or health care professionals, where necessary, to develop person-centred support plans and risk assessments for the person.

Where there was a potential risk of harm in delivering the level of care and support to the person, the deputy manager had produced a number of risk assessments. This ensured the health and safety of the client and the staff providing the care and support.

The provider had produced a mobility risk assessment for one client; however, this had not included the necessity for staff to inspect mobility equipment before use, to ensure it remained safe. The provider must be assured that mobility and lifting equipment has been serviced and maintained in accordance to the manufacturers' guidelines, prior to staff members using this equipment.

The deputy manager had produced environmental risk assessments to cover any potential harm within the client's home. The provider did not have a risk management policy.

The provider had produced fire risk assessments for the clients' homes; however, the person completing the risk assessment had a minimal qualification and there was no evidence that the assessor had incorporated the help of a standard fire-safety risk assessment guide. We recommend that the provider complete all fire risk assessments using the most appropriate guidance and risk assessment tools.

Care plans and risk assessments had been reviewed regularly, following a re-assessment of the client's needs. The client had a copy of their file within their home and staff had access to the information within this file.

Staffing and recruitment
The provider had not recruited staff safely. Records demonstrated that the provider had employed people prior to receiving confirmation of a current Disclosure and Barring Service check. The provider had employed a number of staff who had produced a DBS from their previous or current employer, without applying for an up-to-date DBS, ensuring of receiving the most current information on criminal records. The provider had employed a person after receiving a standard DBS check, not an enhanced DBS check, as required.

The provider had requested character references, which were stored on file.

The provider had not produced a comprehensive rota, identifying which staff were expected to attend each clients, and at what time. There were staff timesheets available, identifying the time spent with a client; however, there were no records to confirm if staff had arrived and left the client on time.

There was always at least one member of staff available on standby, to cover any shortfall in staffing, or late calls to clients due to any incidents causing a delay. The responsible person and deputy manager also made themselves available to cover any shortfall in staffing, caused by staff annual leave, unexpected sickness absence or late calls to clients outside of office hours.

Action we require the provider to take

Key areas for improvement:

- Action is required to ensure the safeguarding policy and procedure is fully updated to include identifying the different types of abuse, what staff need to do if they recognise any signs of abuse and comprehensive information regarding who they can report their concerns.
  This improvement is required in line with Regulation 6 of the Care Services Regulations 2103 - Safeguarding

- Risk assessments for the use of mobility aids and lifting equipment must include staff completing visual checks of the equipment for potential defects, and the equipment has been serviced by a competent person within the manufacturer's recommended timeframe.
  This improvement is required in line with Regulation 22 of the Care Services Regulations 2013 - Fitness of premises: Health and Safety

- Action is needed by the provider to ensure they have a risk management policy.
  This improvement is required in line with Regulation 6 of the Care Services Regulations 2103 - Safeguarding

- Action is required to ensure that all pre-employment checks are completed prior to staff commencing employment.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing

- Action is necessary for the provider to develop a staffing rota; identifying which staff member is visiting each service user, their proposed time of arrival and departure, and their actual time of arrival and departure, if this is different.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of Care Service

Inspection Findings

C2 Is the service effective?

Our findings
Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence. The service does require improvements in this area.

This service was found not to be effective in line with the inspection framework.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
All clients had a comprehensive assessment of needs and choices completed prior to receiving a service. All clients also had care plans and risk assessments in place, guiding staff on how to support the clients and meet their individual needs.

The staff handbook had guidance for staff regarding equal opportunities and non-discriminatory practice in the workplace; however, the provider did not have an equal opportunities or Equality, Diversity and Inclusion policy and procedure. This will be an area for improvement.

A file containing the care plans and risk assessments of the client was kept in their home. Staff had access to this file during their visits. Staff told us that the care plans and risk assessments were updated whenever the needs of the clients had changed, or annually, at their review.

Staff had the appropriate skills and training to meet the individual needs of the clients.

It is good practice to consult with carers and families, either where this is agreed with the person themselves, or in the best interests of people who do not retain mental capacity for their care and support. Feedback from service user's and/or their family members demonstrated that the service users had been supported during the initial meetings, when setting up the service, and with their continued care.

We do not have Mental Capacity Act legislation currently on the island, however, there is an expectation all health and social care providers operate to best practice principles. For clients that did not retain the mental capacity to agree to the level of care and support provided by the agency, there were no records of a capacity assessment or of best interests decision meetings, in line with those best practice principles.

Staff support; induction, training, skills and experience
Staff had completed an induction programme. The responsible person or deputy manager had signed off each section upon completion.

Staff had not received a minimum of four one-to-one supervisions, with their line manager, per annum. This will be an area for improvement under the 'Well Led' domain.

Staff had not completed all mandatory training, identified within the Domiciliary Care Minimum Standards (Isle of Man Department of Health and Social Care). The provider had not identified dates for refresher training, to ensure all staff remain up-to-date with their training.

Staff had not completed additional training to meet the individual needs of the clients they attend, for example, dementia training or Parkinson's disease.

One member of staff told us, "I have received some training with my current role and feel I am supported by the deputy manager." Another member of staff said, "I have received training specific to the needs of the service user in my previous job. I feel very confident in meeting their needs."

Feedback from service users, or their family members, informed us that they felt safe with the staff attending them and that they appeared to have the appropriate training.

Records showed that less than 50% of staff delivering personal care had the minimum requirement of holding a Regulated Qualifications Framework (RQF) level two or three, or equivalent.

The responsible person and/or the deputy manager had carried out 'spot-checks' on staff within the clients' homes and had completed a relevant form, identifying any areas for improvement. This form was stored within the service user's file.

The responsible person had conducted regular management meetings with the deputy manager and care supervisor. The responsible person had not carried out staff meetings with any regularity.

Staff had their competency in administering medication to the client assessed on an annual basis.

Action we require the provider to take

Key areas for improvement:

- Action is required by the provider to ensure there is an equal opportunities or Equality, Diversity and Inclusion policy and procedure.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of Care Service

- Action is needed to complete capacity assessments and conduct best interests decisions meetings for clients lacking the mental capacity to make informed decisions regarding their on-going care and support.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of Care Service

- Action is necessary to ensure all staff have received all mandatory training and refresher training on time and evidence of this is available for inspection.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of Care Service

- Action is required by the provider to ensure staff have received training specific to meeting the individual needs of the service users.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of Care Service

- Action is needed to ensure 50% of the staff delivering personal care have attained the Regulated Qualifications Framework (RQF) level two or three, or equivalent.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of Care Service

- Action is required by the responsible person to ensure team meetings are held regularly.
  This improvement is required in line with Regulation 9 of the Care Services Regulations 2013 – Meeting the Minimum Standards

Inspection Findings

C3 Is the service caring?

Our findings
Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. The service does require improvements in this area.

This service was found to be not always caring in line with the inspection framework.

Ensuring people are well treated and supported; respecting equality and diversity
The responsible person and/or the deputy manager had reviewed care plans and risk assessments regularly, together with the client, and their family, when necessary.

A service user guide, setting out what service recipients can expect from the agency, was not available for inspection. The provider must produce a service user' guide, which they keep up-to-date with relevant information, and made available to all service recipients.

The provider ensured that each client had a number of staff assigned to support him or her with their needs. This ensured that the client had consistency of care, if a member of staff was unavailable due to annual leave or sickness absence.

Staff had made daily notes within the clients' file that identified tasks completed by the staff members, and shared any concerns. There was evidence that the service had supported a referral to health care professionals, and other services, if the client's needs had changed significantly.

Client's religious beliefs and communication needs were identified during the initial assessment. We recommend that initial assessments should also ascertain the service user's gender preferences for staff offering support with their personal care.

The provider relied on staff timesheets to identify the length of time the carers had visited the clients. The timesheets showed that, the time between visits to different clients, did not allow for travel time from one to another. This will be an area for improvement.

One person receiving a service told us the carers provided between twenty-five to thirty five minutes care per visit, before leaving; however, the provider was charging the client for one full hour.

Other feedback told us people were happy with the carers that visited them and that they arrived and left on time. Carers often asked the clients if there was anything more they could do before they left their home.

Supporting people to express their views and be involved in making decisions about their care
Service users, their family and significant others were involved in the assessment and care planning process.

The service users had received annual reviews. Feedback from family members informed us that they had been involved with the review process.

The provider kept staff informed of the service users' needs by means of on-going assessments. The responsible person or the deputy manager had reviewed the service users care plans annually, or sooner, if their needs had significantly changed.

How are people's privacy, dignity and independence respected and promoted?
Staff had signed a confidentiality policy to signify their responsibility to keep client' information private.

The provider informed service users of their rights to confidentiality within the statement of purpose.

Paper records were stored within a locked cabinet, in an office, which was locked when not in use.

Action we require the provider to take

Key areas for improvement:

- Action is required by the provider to produce a written guide to the care service, and this is made available to all service recipients.
  This improvement is required in line with Regulation 7 of the Care Services Regulations -Service User Guide

- Action is necessary to ensure staff have an acknowledged period of time to travel between visits to the service users at different locations. This should be established and displayed on a staffing rota.
  This improvement is required in line with Regulation 14 of the Care Services Regulations 2013 – Records

Inspection Findings

C4 Is the service responsive?

Our findings:
Responsive – this means we looked for evidence that the service met people's needs. The service does not require any improvements in this area.

This service was found to be responsive in line with the inspection framework.

Planning personalised care to ensure people have choice and control to meet their needs and preferences
Meeting the needs of some of the clients had included the support and participation from significant other people to the client, including family members and significant others.

Care plans had included information from other services supporting the clients, such as their G.P., district nurses, occupational therapists and physiotherapists. Initial assessments had included support from social workers, where necessary.

The service had reviewed care plans and risk assessments regularly, in line with their regulatory responsibility, or when necessary, to meet the changing needs of the clients.

Care plans and daily records showed that the service had supported clients to keep in contact with community groups, for example, attending day centres, etc.

Packages of care delivered by the service provider were varied to include a number of daily calls to overnight care and support.

Feedback from service recipients told us communication was generally very good and the service was flexible to changes, such as call-time requested.

Staff told us that the management team always informed them if there had been any changes to a service user's care package.

Improving care quality in response to complaints and concerns
The provider had a complaints policy and a complaints log. The provider had not received any formal complaints since the last inspection; however, they had addressed concerns raised by a service user before a complaint was made, which the deputy manager had logged as such and had resolved the issues to the clients' satisfaction.

The provider's statement of purpose contained information on how to make a complaint, ensuring people knew what to expect from the complaints process.

Service recipients told us they felt confident that, if they had a complaint or a concern, they would talk to the responsible person or deputy manager. Service recipients felt that they would address any issues to their satisfaction.

Staff members felt assured that the management team would take any of their concerns seriously and address any issues.

The registration and inspections team had not received any concerns in relation to this service during this inspection period.

Inspection Findings

C5 Is the service well-led?

Our findings
Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. The service does require improvements in this area.

This service was found not to be well-led in line with the inspection framework.

Does the governance framework ensure that responsibilities are clear and that quality performance and risks and regulatory requirements are understood and managed?
Systems were in place for monitoring and reviewing the quality of care provided to the service users. The provider sought feedback from the service users every six months. The results of which were published in the providers' annual report.

The deputy manager conducted 'quality assurance home visits', to assess the care provided by the carer and to receive feedback from the client. The deputy manager also checked on the quality of the daily log entries and completed a form specific for the purpose of this visit.

There was no evidence that the provider had completed a minimum of four one-to-one supervisions with staff members, in the previous year. Staff had their competency in administering medication assessed on an annual basis.

The responsible person had not submitted notifications of all significant events to the Registration and Inspection team in line with regulatory requirements under the Regulation of Care Act 2013

The deputy manager told us there had been no missed calls since the last inspection, although there was no structured system in place to monitor and evidence this. There was no procedure or protocol for staff to follow in the event they were going to be late to a call, or were not able to meet with the service user. This will be an area for improvement.

The responsible person had delegated a number of managerial tasks to the deputy manager and administrator/care supervisor. The deputy manager had a current up-to-date job description identifying their role and responsibilities.

We reviewed a number of the provider's policies and procedures. A number of them required reviewing and were out-of-date. This will be an area of improvement.

We reviewed the service users Medication Administration Records (MAR) sheets; used to record when a service user had been administered medication by a member of staff. The provider must review this document to ensure it conforms to the requirements under the UK Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the Providers' statement of purpose. This did not have a review date and some information within the document was significantly out of date. The statement of purpose did not contain all of the information to conform to current regulations. This will be an area for improvement.

We received mixed feedback from staff members. One staff member said, "I am very happy working for Able Homecare. [The manager] is the best boss I've ever worked for and Able Homecare is a good place to work." Another staff member told us, "Sometimes, I feel that the manager supports me; sometimes they never seem to follow through with any changes. We often get reassurances but very little changes."

How does the service work in partnership with other agencies?
Information contained within the service users care plans, and feedback, demonstrated that the provider had worked in partnership with other agencies.

Action we require the provider to take

Key areas for improvement:

- Action is required by the manager to ensure that all staff members receives a minimum of four one-to-one supervisions per annum.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing

- Action is required by the responsible person to ensure that the Registration and Inspection Team are notified of all events identified within Regulation 10 of the Regulation of Care (care services) Regulations 2013.
  This improvement is required in line with Regulation 10 of the Care Services Regulations 2013 – Notifications.

- Action is needed to ensure that there is a procedure or protocol in place, informing staff what to do if they are late to a visit, or unable to attend a visit to a service user.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of Care Service

- Action is necessary to ensure that all policies and procedures are reviewed regularly and information within them is current and correct.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of Care Service

- Action is needed to ensure that Medication Administration Records conform to the requirements under the UK Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
  This improvement is required in line with Regulation 14 of the Care Services Regulations 2013 – Records

- Action is needed to ensure the providers' statement of purpose conforms to the Schedule 3 of the Regulation of Care (Registration) Regulations 2013.
  This improvement is required in line with Regulation 5 of the Care Services Regulations 2013 – Statement of Purpose

If areas of improvement have been identified the provider will be required to produce an action plan detailing how the areas of improvement will be rectified within the timescales identified. The R&I team will follow up and monitor any actions undertaken.