

Advance Health Care UK Ltd

Advance Healthcare (UK) Limited

Inspection report

Saturn Place Suites G11A & G11B
Spring Road, Ettingshall
Wolverhampton
WV4 6JX

Tel: 01922626731

Date of inspection visit:
05 January 2023

Date of publication:
09 March 2023

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Advance Healthcare (UK) Limited provides personal care and support to people living in their own home. The agency provides care and support for older people, adults with disabilities and people who live with dementia. At the time of our inspection visit, services were being delivered to 159 people.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wide social care provided.

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

Since the last inspection, the provider had taken on another company, staff and their service users. Not all staff felt well informed regarding the merger of the 2 companies and felt communication could be improved.

The provider's audits had not identified areas for improvement that were found on inspection. People were supported by a group of staff who knew them well, but care records did not always hold the most up to date information regarding people and their care needs. Current systems in place to monitor call delivery times were not always effective, which resulted in some people experiencing early or short calls.

People felt safe when supported by staff in their own home and were supported by a consistent group of staff who had been safely recruited. People were supported by staff who followed the latest infection control guidance when providing care. Accidents and incidents were reported and acted on and analysed for any lessons to be learnt.

People were complimentary of the staff who supported them. Staff felt supported but said they would value face to face training rather than online training. Staff were aware of people's nutritional needs and supported people to attend healthcare appointments. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People's feedback of the service was being sought and this information was used alongside other audits to help drive improvement.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection. The last rating for this service was good (published 18 March 2020). Since this last rating was awarded the registered provider has moved premises. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected

This inspection was prompted by a review of the information we held about this service.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Advance Healthcare (UK) Limited on our website at www.cqc.org.uk.

Follow up

We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Requires Improvement ●

Is the service effective?

The service was effective.

Good ●

Is the service well-led?

The service was not always well led.

Requires Improvement ●

Advance Healthcare (UK) Limited

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team

The inspection was carried out by 1 inspector. An assistant inspector rang people who used the service and their relatives following the inspection.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection

We used information gathered as part of monitoring activity that took place on 22 August 2022 to help plan the inspection and inform our judgements. We also reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with 4 people and 7 relatives over the telephone. We also spoke with 12 members of staff including the registered manager, the regional manager, the deputy manager, a care co-ordinator, field supervisor and care staff. We looked at 3 staff recruitment files, training records, a variety of audits and 6 care plans.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at audits and training records.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- People were supported by staff who were aware of the risks to them, but some care plans and risk assessments did not always hold information regarding those risks or lacked detail.
- For example, for one person who received medication for epilepsy, there was no care plan or risk assessment in place to advise staff on how to support them safely if they experienced a seizure. A member of staff told us, "There's nothing in the care plan about [person's] seizures, but I have had training [first aid] and know what to do." They went on to describe the actions they had previously taken when the person had suffered a seizure, including making them safe and calling an ambulance. A care plan and risk assessment was put in place immediately following the inspection.
- Despite some information being missing from files, people told us they felt staff were well trained and felt safe when supported by them.

Staffing and recruitment

- There were systems in place to monitor call time delivery, but the times some people received their calls did not always reflect what was originally agreed at the start of people's care. This meant the provider could not be confident people were consistently receiving their calls at the times agreed. The registered manager and deputy manager advised where people had requested changes to their call times [and this had been accommodated], the electronic system could not be updated without authorisation from the local authority. They told us they saw this piece of work as a priority to ensure the correct information was recorded on their system.
- The majority of people spoken with told us they were supported by a consistent group of staff who usually turned up on time. A relative told us, "The carers are excellent, and I would not want to change it in any shape or form. Same carer in the morning, first class. Mixed carers in the evening. I do not have any complaints of the Advanced carers, nothing but praise." Another said, "Generally quite punctual, but in an emergency will call before [if running late] which cannot be avoided."
- However, this was not everyone's experience. One person told us, "Calls are ok on and off, morning call ok, but lunchtime call is half hour early. I told them; they keep saying they have a lot on. It is all the time. Every week." A relative told us "We have had missed calls on 2 occasions when they have struggled to get staff."
- Recruitment checks were completed to ensure staff were safe to work with people. This included obtaining references from previous employers and checks with the Disclosure and Barring Service (DBS). These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

- People spoke positively about care staff, demonstrating they felt safe when being supported by them. A relative told us, "Really nice carers that really care for [person] because they can't talk and do not always understand. So, we are really pleased with the carers. It is nice we have the same carers that look after their needs. A big thank you to them."
- A member of staff told us, "I think people are safe, there are conversations leading up to the call about what people need and how they need to be supported."
- Where safeguarding concerns had been raised, appropriate action had been taken. However, the registered manager had failed to notify CQC of a safeguarding concern, as required to do so by law, that had been brought to their attention. This was immediately rectified during the inspection.

Using medicines safely

- People were supported by staff who had received training in how to support them, where appropriate, with their medication.
- People who received support with their medication told us they had no concerns regarding the support they received. A relative told us, "They do check [we are happy with the service] and go through [person's] medication."
- Staff were aware of the circumstances in which to raise any concerns regarding people's medication, for example if there were issues with their medication supplies. A member of staff told us, "If someone said they did not want to take their medication, I would leave it a while and try encourage them again. If they refused, I would report it on the feedback form on the [electronic] tablet. The office pick this up."

Preventing and controlling infection

- People were supported by staff who had received training in preventing and controlling infection.
- People told us staff wore appropriate Personal Protective Equipment (PPE) when entering their homes and supporting them with their care.
- Staff confirmed they had access to plentiful supplies of PPE.

Learning lessons when things go wrong

- Systems were in place to carry out an analysis of accidents and incidents on a monthly basis. Individual actions were taken in response to concerns raised.
- The latest analysis of this information had not identified any patterns or trends for future learning. However, it was identified that call time delivery was an area that required improvement and actions were being taken to address this.

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.

At our last inspection we rated this key question good. At this inspection the rating has remained good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
Supporting people to live healthier lives, access healthcare services and support, Staff working with other agencies to provide consistent, effective, timely care

- People's needs and choices were assessed prior to receiving care from the service and staff spoken with were aware of people's health care needs, how they wished to be supported and what was important to them.
- People were supported by staff to access healthcare appointments where appropriate. One person told us staff had also been flexible around their call time to accommodate a hospital appointment.
- People and their relatives were confident staff would contact healthcare professionals on their behalf if they became unwell.

Staff support: induction, training, skills and experience

- Whilst staff told us they felt well trained, they also told us they would appreciate the opportunity of receiving some refresher practical moving and handling training to ensure they continued to support people safely and effectively. A member of staff said, "There's a lot of training on the computer, but no face to face training for a while; it would be nice to see someone face to face." Another said, "I haven't done any refresher training since I started, [it's important] especially as there is new equipment [to use]."
- Staff confirmed their competencies were regularly assessed. However, the registered manager advised this was an area they had identified for improvement and a plan had been put in place to address this.
- A training matrix showed a number of staff had not received any updates in training since they commenced in post. The registered manager advised, and staff confirmed they were currently in the process of completing on-line refresher training in all areas covered by the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
- People were supported by staff who received an induction which included shadowing more experienced colleagues. A member of staff said about their induction, "The girls [care staff] I shadowed with shared a lot of information and told me everything I needed to know about equipment and I watched and got involved and they just made me feel at ease."

Supporting people to eat and drink enough to maintain a balanced diet

- Where people required support at mealtimes, they were supported by staff who were aware of their likes and dislikes, dietary needs, and how their meals should be prepared. A member of staff described how they prepared one person's meal and how they supported them to eat their lunch. They told us, "We ask people

and they tell us what they want us to prepare."

- People's care records provided staff with information regarding their food and drink preferences and where appropriate, their dietary needs.

Ensuring consent to care and treatment in line with law and guidance

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

- People told us staff obtained their consent prior to supporting them. A relative told us staff obtained their loved one's consent before supporting them, adding, "They [care staff] talk to [person] and tell them what they are doing".
- Staff respected the rights of people with capacity to refuse their support and ensured people with capacity gave their consent to being supported. A member of staff told us, "We have a policy, we would never force anyone to do anything".
- Staff respected people's choices in their day to day lives and supported them in making daily decisions such as what to eat at mealtimes.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Since the last inspection, the provider had taken over another domiciliary care service and merged the staff and client group. Following this, a number of staff and the former registered manager of Advanced Healthcare (UK) Limited left the service. In November 2022, the service had to move to another office at short notice.
- Staffs' experience of the merger of the 2 services and introduction of some new systems and processes was inconsistent. Whilst some staff had no concerns and felt informed, others felt the opposite and told us communication with management had been and continued to be poor. One member of staff said, "You don't know what's going on, this is the first staff meeting for months, the last one was in October and we were told the next would be in 6-8 weeks." Another commented, "If you ring the office and ask for someone you have to wait for them to ring back and they don't always."
- Systems and processes to ensure monitoring and oversight of the service had failed to identify some issues found on inspection. For example, an epilepsy risk assessment was missing in one person's care file and in another, there was a lack of detailed instructions for using a hoist during moving and handling techniques. We were told work was ongoing to review people's care plans and ensure they reflected people's needs and provided staff with the information required to support people safely and effectively.
- The provider's audits had identified that some people's calls were not being delivered in line with their agreed care plan. The current information held by the provider regarding call delivery times did not provide a true picture of people's experience of the service. This was a piece of work the registered manager was trying to correct.
- The regional manager told us they did not intend to increase the numbers of people they supported, in order to ensure they could deliver calls on time and for the correct length of time, whilst they addressed this problem.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- The majority of people were happy with the service they received and spoke positively about the carers who supported them or their loved ones. A relative described the service as, "Very nice, professional. They are very good with my relative." Another said, "Apart from the merger and people leaving, it's not affected me. The carers are the same, the reliability is the same. Given the climate at the moment and staffing situation, I think they are doing quite well." However, not everyone had such a positive experience. One person told us, "Sometimes things get lost in communication; they [management] need to communicate a

bit more."

- Staff spoke positively of the new registered manager who had been in post since August 2022. They told us they found them to be supportive and approachable.
- The provider had an action plan in place and had identified a number of areas for improvement, including managing staff absence and introducing regular team meetings to help focus on building relationships with staff. Feedback from people using the service was sought, to help drive improvement.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Despite the registered manager normally notifying CQC of incidents [as required by law], we identified an incident CQC had not been informed of. This was rectified during the inspection when it was brought to their attention.
- Staff were aware of the provider's whistleblowing policy and told us they were confident they would be listened to if they raised any concerns.
- Staff meetings were taking place, but some staff raised concerns regarding communication, the introduction of new ways of working, and were not fully aware of other staffs' roles and responsibilities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People spoke positively on the whole about the staff who supported them, but also raised concerns about the timings of some calls and the lack of response from the provider in dealing with these concerns.
- Staff were aware of the provider's whistleblowing policy and were confident if they raised concerns they would be listened to. A member of staff told us, "I always have the same run and any changes come through the phone. Sometimes extra calls are put on you and if you don't check your phone regularly you wouldn't know. I did complain about it and it is better now."
- People confirmed their opinions of the service were sought through phone calls and surveys.

Working in partnership with others

- The registered manager and staff continued to develop working relationships with health professionals and the local authority and worked to implement any recommendations made.