Agape Healthcare Limited

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Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 16 December 2014 and was announced. We gave the provider 48 hours notice that we intended to inspect the service. This allowed the provider time to collect information about the care people received in their homes which we might have wanted to review.

Agape Healthcare Limited is a domiciliary care agency which provides personal care to people in their own home. At the time of our inspection six people were receiving personal care from the service. There was a manager at this location however they were not registered with us. 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 and associated Regulations about how the service is run.

At our last inspection in June 2014, we found that the provider had breached regulations relating to how

Summary of findings

people at the service were supported and kept safe. They had also breached regulations relating to how they monitored the quality of the service and record keeping. The provider sent us an action plan to tell us the improvements they were going to make to ensure the service would comply with the regulations. At this inspection we found that the provider had not completed all actions that they had promised. We saw that the provider had reviewed some care plans and updated risk assessments but had still not taken sufficient action to meet the appropriate regulations. You can see what action we have told the provider to take at the back of the full version of this report.

The provider did not have robust systems to monitor the quality of the care provided or identify, assess and manage risks relating to the health and welfare of people who used the service. The provider did not have a robust system to review the quality of the service. The provider had not ensure that new staff were recruited in line with their policies or ensure that staff had the skills and knowledge to safeguard the health, safety and welfare of the people who used the service. The provider had failed to take suitable action in response to our last inspection and we found that some of the concerns raised were still unresolved. You can see what action we have told the provider to take at the back of the full version of this report.

People who used the service told us that they were confident that care was provided in accordance with their needs. Four people who used the service and three members of staff who we spoke with, all told us that they felt people at the service were safe. However peoples care records did not always contain information and guidance staff required to ensure they supported people safely. Information about people's specific conditions and how they were to be supported was not always transferred when assessments were updated.

The provider did not have a robust recruitment process to check if staff were suitable to support people. The relatives of two people who used the service told us they felt their relatives were safe and that staff understood their needs however records showed that the provider had not followed up gaps in staff employment history or obtain independent references to identify if staff were fit to support people. You can see what action we have told the provider to take at the back of the full version of this report.

People told us that they felt confident staff supported them to take medication safely however records did not always contain clear guidance for staff to follow which could result in medicines not being administered safely. The provider had not taken action when they identified that staff required training in how to support people to take their medication safely.

People who used the service and their relatives told us that they felt there were enough care staff to meet people's care needs and that they were consistently supported by the same staff members. This had helped people to build up close relationships with the care staff who provided their personal care.

Records showed that the provider had mostly recruited staff that had previous experience and qualifications in social care. However, not all staff had undertaken induction or training to address gaps identified in their skills and knowledge. You can see what action we have told the provider to take at the back of the full version of the report.

All the people we spoke with said that they were supported in line with their care plans. The relative of a person who lacked capacity told us that they were regularly approached by care staff or the manager to discuss how care was to be delivered. The manager and staff were unsure about their responsibilities in ensuring people were supported in line with the Mental Capacity Act 2005. Staff had not received training to help them understand their responsibilities. You can see what action we have told the provider to take at the back of the full version of the report.

People were able to express any concerns about the service they received. However several people told us that the manager did not always respond promptly to concerns raised. We saw that action was not always taken when it was identified that people's care needs had changed.

The provider had not responded to all the concerns we raised at our last inspection. We saw that the provider's systems for monitoring the quality of the service and staff training were still in breach of current regulations. The

Summary of findings

manager had not identified errors and omissions in care records or poor recruitment and training practices. The provider did not have a system to record concerns or learn from untoward incidences.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe. Care records did not always contain sufficient information so staff would know how to provide care which kept people safe.

The provider did not always carry out sufficient checks when they employed staff to identify if they were of good character.

Is the service effective?

Requires Improvement

The service was not effective. The provider did not always respond when they identified that staff did not have the skills and knowledge to meet people's care needs and protect people's legal rights.

The provider had not ensured that staff were sure about their responsibilities in ensuring people were supported in line with the Mental Capacity Act 2005.

Care staff knew how to support people to ensure they received enough food and drink to keep them well.

Is the service caring?

Good

The service was caring. People had developed meaningful relationships because they were regularly supported by the same staff.

Care staff knew people's preferences and provided care in line with people's wishes.

When possible the provider ensured that people were supported by care staff who knew their cultural and religious preferences.

Is the service responsive?

Requires Improvement

The service was not responsive. The provider did not always respond when it had been identified that people's care needs had changed.

The provider responded when people raised concerns however this had not always been in a timely manner.

People told us that staff supported them in line with their wishes.

Is the service well-led?

Inadequate

The service was not well-led. The systems in place to check on the quality and safety of the service were not fully effective or ensured people were benefitting from a service that met their needs.

The provider had not ensured that a registered manager was in place.

The provided had not responded to all the concerns raised at our last inspection.

Agape Healthcare Limited

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 16 December 2014 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and this allowed the provider time to collect information about the care people received in their homes which we might have wanted to review.

The inspection team consisted of two inspectors.

Before our inspection we checked if the provider had sent us any notifications since our last visit. These contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. The provider had also submitted a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed an action plan the provider had sent us in response to concerns raised at our last inspection. We used this information to plan what areas we were going to focus on during our inspection.

Before our inspection we spoke to a person who commissioned services to obtain their views of the service. During our inspection we spoke with two people who used the service and the relatives of two further people who the service provided personal care to. We also spoke to the manager and three staff who worked at the service.

We looked at records including four people's care plans. We also looked at records of staff training to see if the provider had addressed our concerns from our last visit. We looked at the provider's records for monitoring the quality of the service and how they responded to issues raised.

Requires Improvement

Is the service safe?

Our findings

Two people who used the service and three members of staff who we spoke with, all told us that they felt people at the service were safe. The relatives of two people also told us they felt their relatives were safe and that staff provided care in a safe manner.

The provider did not have a robust recruitment process to ensure that staff were of good character and safe to work with people. All the staff we spoke with told us that they had an interview with the manager before they joined the service however a review of the provider's records showed that they had not attempted to gain additional information when staff had failed to provide independent references. The manager also told us that they had allowed a member of staff to start providing support to a person before they had received a response from the Disclosing and Barring Service (DBS). A DBS check identifies if a person has any criminal convictions or has been banned from working with people and therefore helps the provider to assess if the person is suitable to support people who use the service. The manager advised that one member of staff who had specific language skills had been employed to provide care without any of the routine checks being carried out. This is a breach of Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of the report.

A member of staff we spoke with could explain the principles of safeguarding and was confident to take action if they felt a person was at risk of abuse. Two other staff we spoke with were not clear about who they could report safeguarding concerns to outside of the provider's organisation. However, they both stated that they consistently supported the same people and would quickly recognise if a person's condition had changed and would report any changes in a person's condition to the manager. People who used the service and the relatives we spoke with all said the manager and staff were approachable should they need to raise concerns about a person's welfare.

People told us that the manager had met with them before they joined the service to discuss their care and the support they needed to be kept safe. All the people we spoke with said that they felt safe when staff were supporting them with their mobility and providing personal care. The provider had conducted assessments of people's care needs and when necessary had produced guidance for staff about how to manage the risks associated with a person's specific condition. Staff told us that the care plans provided enough information so they felt confident that they could provide care safely. However we saw that risk assessments did not consistently contain information and guidance staff required to ensure they supported people safely if their condition changed. For example an assessment for a person who was known to be at risk from tissue breakdown did not clarify what staff should be observing for, what they should do if the person had any sore skin, if they should record skin checks or if any other equipment should be available. We spoke to the manager about this and they were unable to clarify the procedure staff were required to follow. The provider had failed to ensure that staff had access to all the guidance and information they needed to ensure people were kept safe from the risk of harm.

People told us that they felt confident staff supported them to take medication safely. The relative of a person who was at risk of taking their medication inappropriately told us that staff knew how to store the medication safely so that it was only available for the person to take at the prescribed times. Records showed that one person had medicine prescribed as required but they did not have a care plan or risk assessment in place for their medicines. The manager confirmed there was no written guidance for staff to indicate when the person should have this medicine and they were unable to clarify the provider's policy for administrating as required medicines. A lack of guidance could mean people have medicine when unnecessary or they do not receive it when required.

Information about how to support people to take their medication safely was not consistent. Two of the files reviewed included risk assessments for medicines and one file also included specific details of how staff were to administer the person's medicines. This person had refused their medicines on occasions and the instructions stated that if this happened to contact the office immediately. However the risk assessment stated that if the person refused staff were to leave a message for the family as agreed and they would give it to them later. Records did not contain clear information to enable staff to ensure medicines were administered safely.

Requires Improvement

Is the service safe?

People who used the service and their relatives told us that they felt there were enough care staff to meet people's care needs and that they were consistently supported by the same staff members. The relative of a person told us, "They know [person's name] moods. That is the pleasure of having consistent staff." People told us that staff generally turned up on time and that two staff attended when it had been assessed as needed and staff signing in sheets confirmed this. The provider maintained a pool of bank care staff who were available to cover shifts when staff booked to work were unavailable. The signing in sheets we looked at supported people's views that the correct number of staff turned up on time. The provider had ensured that there were enough care staff available to meet the needs of the people who used the service.

Requires Improvement

Is the service effective?

Our findings

We noted that the provider had not always taken action when they had identified gaps in peoples knowledge and staff had not received any dedicated training in some specific areas of care such as safeguarding or the safe administration of medication. The manager did not hold regular supervisions or meetings with staff to ensure that staff maintained the skills and knowledge they needed to provide care in line with people's care plans. The manager told us that this needed to be done however they had not had the time. There was a risk that people were supported by staff who did not have the necessary skills and knowledge to meet their specific care needs. This is a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of this report.

The manager was unable to explain the principles of the Mental Capacity Act 2005 or clarify the provider's policy for assessing if a person lacked capacity. Staff we spoke with were also unclear as to the provider's policy for assessing if a person lacked capacity. Staff had not received any specific training about the Mental Capacity Act or about how they would help people make decisions and not impose any authorised restrictions on people. This meant that people were not safe from having their rights restricted inappropriately. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of this report.

All the people we spoke with said that they were supported in line with their care plans. A person who used the service told us, "I always have the same carer, they look after me very well." Another person told us, "They [care staff] are very attentive. They know how to help me to stand." We spoke to a person who commissioned care packages from the service and they told us that they felt that the care provided met people's needs.

Staff told us that they felt confident they knew how to meet the care needs of the people they supported. They were also able to demonstrate they knew people's preferences and choices and explain what people liked to do and how they wanted their care delivered. When possible the provider had ensured that people were matched with care staff who knew how to meet their specific cultural and religious needs and could communicate with them in their preferred language. Staff were well matched to the people they supported.

All the people we spoke with said that care staff knew the care people needed to maintain their welfare and had no concerns about how their care was delivered. The provider had mostly recruited staff that had previous experience and qualifications in social care and conducted assessments of people's knowledge and experience to identify if they had all the skills needed to support the people who used the service. Staff we spoke with told us that they received a general induction when they started working at the service but the manager confirmed that some staff who provided care had not received an induction.

People told us that they had been involved in contributing to their care plans and felt that their care was delivered in line with these wishes and that the manager would seek their views to check. When a person was believed to lack capacity we saw that they had been supported by relatives and social workers to make decisions which would be in their best interest. People had signed their care plans when possible expressing their consent to how their care would be delivered. When a person was unable to provide consent we saw that a relative had been involved to ensure that the proposed care plan was in line with the person's needs and values The relative of a person who lacked capacity told us that they were regularly approached by care staff or the manager to discuss if care was being delivered in line with their preferences.

Care staff told us that they knew how to support people to ensure they received enough food and drink and a relative said that care staff had recently worked with them to support a person to eat healthier. Care plans identified what support people required to receive enough food and drink to keep them well, however we saw that care staff did not always record if they had provided people with breakfasts or lunch. This meant that it was not always possible to identify if people were receiving enough nutrition and fluids to maintain a balanced diet.

Care records had information for staff about how to support people's specific conditions and when they needed to approach other healthcare workers for additional support. The records of a person who was at risk of pressure sores showed that they were regularly attended

Requires Improvement

Is the service effective?

by a district nurse and care staff were monitoring the person's condition in line with the nurse's instructions, however not all records were fully completed. The provider told us that they had on occasion supported people to attend hospital appointments when family members were unavailable. This ensured that people were supported to maintain good health.

Good

Is the service caring?

Our findings

A person who used the service told us, "I always have the same carer who always looks after me." A relative we spoke with told us that staff took an interest in the person they supported and knew what they liked to eat. All the people we spoke with felt that staff were concerned about their welfare and looked forward to their visits.

All the people we spoke with told us that they were supported by regular care staff. A member of staff we spoke to said they were happy to work over their shift when the person they were providing care to required additional support because they cared about the person's welfare and feelings. This had helped people to build up close relationships with the care staff who provided their personal care.

It was evident from the staff we spoke with that they knew the people who used the service well and had learned their likes and dislikes. They knew what was important in the lives of the individuals. A member of staff told us they knew what a person liked to eat and enjoyed supporting the person to eat meals they enjoyed. Care records contained details of what was important to people and this enabled staff to deliver care in line with people's wishes and preferences.

The manager told us that they called each person who used the service or their representative regularly to check that people were receiving care which met their needs. This enabled people to express any concerns about the service they received. People we spoke with told us that they felt listened to and their views were respected. A relative of one person who used the service told us that the manager took action when they raised concerns about a member of staff. This meant that the provider was interested in people's wellbeing and people were able to express their views about the care and treatment they received. However the provider did not review people's views for common themes in order to prevent incidence from occurring to other people who used the service.

The manager told us that when possible they would arrange that people who used the service were support by staff who shared the same cultural background and language. This helped ensure peoples' dignity and privacy was respected in line with people's cultural and religious needs. Care files and daily records showed that people were asked how they wanted to be addressed by staff and that they were referred to by the name of their choice. All the care plans we reviewed instructed care staff to respect people's privacy and dignity however there were not always detailed guidance on how staff were to do this. We saw that the provider's induction training included explaining how care staff should respect people's privacy but not all care staff had undergone this training. We spoke to three care staff and they were able to explain what measures they took to respect people's privacy and dignity.

Requires Improvement

Is the service responsive?

Our findings

People who used the service told us that staff were responsive to their needs. They told us that staff took time to find out what they liked and supported people in line with these wishes. One person who used the service told us, "They change how they do things depending on my condition and if I am having a good or bad day". Another person told us, "I am very happy with the service, they sorted out all the hic cups." The relative of a person who used the service said, "We raised concerns about different staff turning up, but that was sorted out and we get the same carer now."

We saw that the provider met with people before they received a service to identify how people wanted their care delivered and these preferences were reflected in people's care plans. For example, the care record of one person contained details of how the person wanted to be supported to wash. A member of staff we spoke with explained how they responded to instructions from a person who was visual impaired so that they were aware of their presence when they arrived at their home. This ensured that people contributed to their care plans and could express the level of support they needed to achieve the quality of life they wanted.

The provider sought advice from other health care professionals when people's conditions deteriorated and when necessary staff changed their practices to support people in line with the latest advice. However, the provider did not always respond promptly to requests for support. For example, six weeks prior to our inspection a person who used the service had requested an extra call due to their changing condition but the provider had not taken action by the time of our inspection.

Staff did not always have the most appropriate information to meet people's current care needs because the provider did not ensure care records were updated in response to people's changing conditions. For example, the provider had identified that a person's condition had changed considerably however, no changes had been made to their care plan to reflect that the person was less able to be involved in their personal care The manager stated he was aware that updating of care plans had not been managed in a timely manner.

People we spoke with told us that the provider had responded when they raised concerns about the service, and provided examples of when this had happened. We saw that where people had asked for the times of their calls to be changed this had been accommodated by the service. The manager told us that they had not received any formal complaints since our last inspection and we saw there was a policy in place to ensure formal complaints would be investigated and complainants would receive an appropriate response.

The manager told us that they regularly called each person who used the service or their representatives to identify if people had any concerns about the care they were receiving. Most people we spoke with told us that they felt they had regular contact with the provider and had the opportunity to raise any concerns promptly. One person told us that they did not have regular contact with the manager but was confident to raise concerns with the care staff and that they would be acted upon. At our last inspection we were concerned that the manager did not keep records of their conversations with people who used the service or their representatives. At this inspection we saw that this was still the case. The manager told us that they did not keep records of people's concerns or incidences. The provider did not have a robust system to learn from people's views in order to identify how the service could be improved.

Inadequate

Is the service well-led?

Our findings

At our last inspection we raised concerns with the provider about several aspects of the service such as training for care staff, medication guidance, record keeping and the quality review process. The provider responded and told us of action they would take to address the concerns. At this inspection whilst we noted that the provider had addressed some of these issues or introduced changes, some shortfalls were still unresolved. The manager told us that they had not had time to update care records and the provider told us that they did not have the financial resources to provide training to staff. The provider had not improved their processes to review the quality of the service. The provider did not have regard for reports raised by the Commission following previous inspections when some of these issues had been identified as needing to be resolved. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of this report.

The provider had a system for reviewing the quality of the service but this was ineffective. The provider had not identified when care records had not been updated as people's conditions changed or information was missing. Information required to ensure people received care which kept them safe was not always carried forward when assessments were updated. Records contained information that was not current and often provided contradictory instructions for staff about how to care for people in line with their current needs. It was the provider's policy to conduct monthly reviews of each person's care plans however, the manager told us that since our last inspection six months ago they only had time to conduct a quality check of one person's daily notes. The review of these notes was ineffective because they had not provided any direction to staff when they identified they needed to improve their performance. The system used by the provider to monitor records could not ensure that people were receiving care in line with their assessed needs

The provider had not made arrangements to ensure the service had a registered manager. The former registered manager applied to deregister in August 2014 but the provider had taken no action to ensure that in the absence of a registered manager that a suitably competent and skilled person would be responsible for the management of the service until a new manager was appointed and registered. The manager told us that they were intending to apply to become the registered manager however the provider had not ensured they had done so. Failure by a provider to ensure a registered manager is in place is contrary to Regulation 6 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Health and Social Care Act (2008).

The provider did not have a robust system to monitor and review the views of the people who used the service. People who used the service said they had regular contact with the manager or care staff who supported them who also kept them informed about the service. The manager told us that they regularly spoke to people to obtain their views of the service and ask if care staff had attended calls on time. However the manager did not record these conversations or review them in order to identify if the service was being provided in line with peoples' care needs and wishes. The lack of records about concerns raised and actions taken meant that there was a risk the provider might not learn from people's experiences and concerns in order to take action to prevent similar concerns from happening again.

We looked at the personal files of four care staff and saw that the provider had failed to identify that the manager had not followed the organisation's recruitment policy. For example the manager had not conducted suitable checks such as following up gaps in employment history or obtaining several references to identify if applicants were suitable to work for the service. The manager told us that they had seen proof of people's legal right to work in the UK but had not recorded it. Despite the lack of checks the manager had employed the individuals. The provider also employed a member of staff based on recommendation although they were unable to interview the person because of language differences. Failing to undertake robust recruitment checks meant that people were at risk of being supported by staff who had not been assessed as suitable t to support people with personal care.

The provider's systems to identify that staff had the skills and knowledge to meet the care needs of the people who used the service was not robust. The provider's systems did not ensure that all staff received an induction in order to learn about the values and vision of the service or receive training when it had been identified that they lacked specific skills. Although staff told us that they had recently

Inadequate

Is the service well-led?

undergone safeguarding training, no evidence had been issued. This meant that the provider could not identify if staff had obtained the required knowledge to keep people safe or if further support was required. The provider did not have system to record when training had taken place or when staff would require refresher training to update their knowledge. Not reviewing if staff had the required skills and knowledge to meet people's care needs meant that people were at risk of receiving care which was unsafe or inappropriate.

At our last inspection we were concerned that the provider did not have effective systems to capture the views of staff and at this inspection we saw that this was still the case. The manager told us that they had only conducted a supervision meeting with one member of staff since our last inspection. The provider had not made arrangements to capture the views of staff whose first language was not English and relied upon the relatives of the people they supported to interpret for them. The provider could not ensure that the information exchanged was accurate or allowed the carer to raise concerns without fear of causing offence or reprisal. The provider did not have a robust system to share their visions and values of the service with staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who used the service were at risk of inappropriate or unsafe care because the provider did not have adequate arrangements to regularly assess and monitor the quality of the service provided. Regulation 10 (1) (a). People who used the service were at risk of inappropriate or unsafe care because the provider did not have adequate arrangements to identify, assess and manage risks relating to the health and welfare of people who used the service. Regulation 10 (1) (b). People who used the service were at risk of inappropriate or unsafe care because the provider did not have regard for reports prepared by the Commission. Regulation 10 (2) (b) (v)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place to ensure staff were aware of their responsibilities under the Mental Capacity Act 2005 to respect people's human rights.

Regulated activity	Regulation
Personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The registered person did not operate effective recruitment procedures to ensure that people employed were of good character. Regulation 21(a)(i)
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider did not ensure that staff had the appropriate skills and knowledge to safeguard the health, safety and welfare of the people who used the service. Regulation 22.