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Academy Care

Inspection report

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Academy Care is a domiciliary care agency providing personal care to people living in their own homes. At the time of our inspection the service was providing personal care to 21 people.

Not everyone who used the service received personal care. The Care Quality Commission 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 wider social care provided.

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

Staff were not safely recruited as the government relaxation around recruitment checks had been misunderstood. Two staff started work without a DBS check and one staff member did not have an interview record as they were recommended to the service. The recording around medicines management was not sufficiently robust. Risks to people had been identified, although there was limited information about how to reduce those risks. Accidents and incidents records lacked detail and were not followed up.

Systems of governance were not effective. Audits had not been carried out from February up to August 2020. Systems had been introduced since our last inspection, although these had not brought the changes needed to demonstrate sufficient managerial and quality oversight. People, relatives and staff spoke very positively about the way the service was run. Staff had been receiving formal support and spot checks of staff were taking place. However, systems used to record this activity needed improvement. People received a service where staff largely arrived on time and there were no missed calls. People confirmed they were supported by the staff who knew their care needs and preferences. Staff were knowledgeable and were competent in using equipment related to people's care needs.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update: The last rating for this service was inadequate (published 26 March 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found evidence of some improvement in these areas, although we have identified that oversight of key aspects of the service provision was still lacking.

Why we inspected

This was a planned inspection based on the previous rating.

We looked at infection prevention and control measures under the Safe key question. This is to provide assurance the service can respond to coronavirus and other infection outbreaks effectively.

We carried out an announced comprehensive inspection of this service on 5 February 2020. Breaches of

legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, formal staff support, systems to provide oversight and safe recruitment.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions of Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Academy Care on our website at www.cqc.org.uk.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement

We have identified breaches in relation to the recording around the safe management of medicines, recruitment and systems used to demonstrate the necessary oversight of the service.

Follow up

We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

Academy Care

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 Care Act 2014.

Inspection team

This inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

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

The service had a manager who was also the provider registered with the Care Quality Commission. This means they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave the service notice of the inspection. This was because it is a small service and we needed to be sure the provider would be in the office to support the inspection.

Inspection activity started on 30 September 2020 and ended on 15 October 2020. We visited the office location on 30 September 2020. We spoke with people and relatives on 12 October 2020 and staff on 15 October 2020.

What we did before the inspection

We reviewed information we received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not

asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with the provider, the office and compliance manager, and the training manager.

We reviewed a range of documents relating to how the service was managed including; three staff personnel files, staff training records, policies and procedures. We looked at records related to protecting people from harm as well as systems used to monitor quality of care.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We spoke with five people who received this service, 11 relatives and three members of staff. We also spoke with a health professional regarding one person's care.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has improved 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.

Staffing and recruitment

At our last inspection we found the provider had failed to ensure systems were in place to demonstrate staff recruitment was safe and effectively managed. This placed people at risk of harm. This was a breach of Regulation 19 (1)(2)(3) Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of Regulation 19.

- Staff were still not safely recruited. We looked at three staff recruitment files and found the necessary background checks had not been made before staff started working for this service. Two care workers did not have a DBS in place at the start of their employment. The provider told us they had misunderstood the relaxation of recruitment checks introduced during the Covid-19 pandemic.
- One staff member did not have an interview record. The provider told us this individual was recommended to them and a formal interview had not taken place. This is not safe practice.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staff recruitment was safe and effectively managed. This placed people at risk of harm. This was continued breach of Regulation 19 (1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed.

- There were sufficient numbers of staff to meet people's care needs.
- People told us they were supported by the same group of staff who they were familiar with and knew their care needs and preferences.
- Call times were reviewed and staff were generally found to be running on time and people confirmed this. People confirmed they had not experienced missed calls. However, we found the provider's systems had identified missed calls as staff had not logged into the digital call correctly to record the care provided. People's daily notes confirmed the call had been completed.

Using medicines safely

At our last inspection we found the provider had failed to ensure the management of medicine was safe. This was a breach of Regulation 12(2)(f) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found some improvements had been made meaning the provider was no longer in breach of Regulation 12. However, medication records were not sufficiently detailed.

- The recording around medicines management was not sufficiently robust.
- Gaps in the administration of some medicines listed on medication administration records (MARs) were found. The registered provider told us they were not responsible for these medicines, although this was not always evident from records we looked at.
- Where the registered provider was responsible for medication administration, MARs did not show the time medicines were due to be given. Staff did not always use recognised codes to record their actions on the MARs.
- Medicine audits had not identified the concerns we found on the MARs.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate medicines were safe and effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

- Since our last inspection, staff had received medication training and had been assessed as competent in safely managing medicines.

Assessing risk, safety monitoring and management

- The risk assessments that were in place needed to be further developed as some risks were not described in detail and there was a lack of written guidance for staff around how to manage and reduce risks to people. Staff had a good knowledge of the people they supported and staff demonstrated a good understanding of risk. There was no evidence this had resulted in any harm to people.
- People requiring equipment as part of their support needs told us staff operated this safely. One relative told us, "[Person] has stacks of equipment and staff know how to use it."

Learning lessons when things go wrong

- The provider had failed to address our concerns identified at the previous inspection. Governance systems were still not effective and audits were not robust. This is discussed further in the Well-led section of this report.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt happy and safe with the service provided by staff. One person told us, "They are careful in what they do. When they move me, they are gentle."
- Staff said they received safeguarding training. The provider contacted the local authority when allegations of abuse had been made.

Preventing and controlling infection

- Infection control measures were safe. The provider was preventing visitors from catching and spreading infections. On arriving at the premises, temperature checks were taken and contact details were provided to comply with government 'track and trace' requirements. Floor markers were being used in the office to help maintain social distancing.
- The provider was using personal protective equipment (PPE) effectively and safely. Staff received training in donning and doffing and had sufficient PPE. People and relatives confirmed staff wore the required PPE on their visits.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were shortfalls in service leadership, meaning we were not assured about the delivery of high-quality care.

At the last inspection we found the provider had failed to ensure effective systems were in place to demonstrate oversight for key areas of the service such as call monitoring times, audits, recruitment and accidents and incidents. This was a breach of Regulation 17(1)(2) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of Regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- After our last inspection, the provider completed an action plan which described the improvements they would make. Although systems had been created to demonstrate oversight, these were not sufficiently effective.
- The provider was unaware of their responsibilities in respect of government guidelines relating to the safe recruitment of staff during the pandemic. The staff training matrix did not record the up to date position of the training staff had completed.
- The office and compliance manager told us audits had not been completed between February and August 2020 which they said was due to the pandemic. However, the provider told us the service itself had not been particularly impacted by the pandemic through reported cases of both staff and people in receipt of the service. Retrospective audits started in August 2020 however, this was a significant period without robust monitoring of the service.
- Accidents and incidents were usually recorded, although two incidents report forms stated (details) 'To be confirmed by [provider]'. Follow up actions and lessons learned had not been identified through these reports.
- Spot checks on staff practice were taking place. However, there was limited recording on these documents. We asked the office and compliance manager if these resulted in follow up action with staff and they told us this was limited due to the pandemic.
- Medication records were not sufficiently robust as identified against our 'Safe' key question. Staff confirmed they had completed the induction training and further development training as required by the provider. The training staff had undertaken was not robustly recorded by the provider however, we observed no impact on people in light of this.

We found no evidence that people had been harmed however, systems to assess, monitor and improve the service were not sufficiently robust and management oversight was not evident over key aspects of the service. This was a continued breach of Regulation 17 (1)(2) of the Health and Social Care Act 2008

Continuous learning and improving care

- The provider had not made sufficient improvements concerning our inspection findings relating to safe staff recruitment at the last inspection.
- The provider had taken steps to make themselves aware of the requirements of the Accessible Information Standard. Communications needs were seen recorded in care plans we looked at.

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

- People and relatives felt fully engaged in the care provided.
- People and relatives we spoke with were overwhelmingly positive about the care they received and added they were safe. One person told us, "Your wishes are adhered to, they always try their best, you're not just a number."
- People were involved in creating their care plans and confirmed they were also included in regular reviews of their care. One relative told us, "I feel listened to."
- People told us they received regular communication from staff. One person said, "They are the best company. It's their attitude, making it the sort of company you wished you had been with before."
- Regular team and managers meetings had been taking place since our last inspection. Staff had received ongoing support through supervision during the pandemic. Satisfaction surveys from people and relatives showed positive feedback.

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

- Feedback from people involved in the service showed they felt listened to and made to feel they mattered.
- People, relatives and staff spoke positively about the provider. Staff told us they were well supported by the provider who they described as caring, responsive and approachable.
- Staff described working in a positive culture and commented that care staff worked hard to ensure people always received a service. One person said, "They [staff] are the only people that visit me, they keep my chin up and make sure that I am alright."

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

- A reportable incident had not been submitted to the Care Quality Commission. This has since been received.
- We looked at the management of one complaint and found suitable steps had been taken to resolve this. A relative told us they were satisfied with the way their complaint had been handled.

Working in partnership with others

- The provider had established links with service commissioners. They told us they received support from a professional association for home care providers.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems introduced to demonstrate oversight of service delivery were not effective. The provider was not aware of their legal responsibilities.
Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff recruitment was not robust.