Acacia Community Care Limited

H+B Homecare Services

Inspection report

Suite 100A, Crown House Business Centre
North Circular Road
Park Royal
London
NW10 7PN

Tel: 02089613785
Website: www.acaciacomcare.co.uk

Date of inspection visit:
26 June 2019
01 July 2019

Date of publication:
19 September 2019

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?	Requires Improvement

Summary of findings

Overall summary

About the service
H+B Homecare Services provides a palliative domiciliary care service for people living in their own homes in the community. At the time of our inspection, there were 12 people funded by the St Luke's Hospice at Home service or the clinical commissioning group (CCG).

People's experience of using this service and what we found
Medicines were not always managed safely and we could not be sure people received their medicines as prescribed. Medicines competency testing was not undertaken and medicines audits were only three monthly. The provider did not have any moving and handling risk assessments to mitigate associated risks when moving people.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Supervisions and spot checks were not consistently undertaken.

The provider did not provide information in any different formats to make it more easily accessible to a wider range of people. Care plans did not have information around end of life wishes.

The provider had systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people but these were not always effective and did not identify issues raised at the inspection.

The provider had systems in place to safeguard people from the risk of abuse and staff knew how to respond to possible safeguarding concerns. Safe recruitment procedures were in place. Staff followed appropriate infection control practices to prevent cross infection.

People's needs were regularly assessed to ensure these could be met. People were supported to maintain health and access healthcare services appropriately.

Staff were kind and respectful of people's wishes and preferences and provided support in a respectful manner. Staff respected dignity and provided day to day choices for people.

There was a complaints procedure in place and the provider responded to complaints appropriately.

People using the service and staff reported the registered manager was approachable and promoted an open work environment.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Responsive and Well Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. Since the inspection the provider had begun to take action to mitigate risks identified during the inspection.

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 29 December 2016).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

H+B Homecare Services

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
The inspection was carried out by one inspector.

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

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

Notice of inspection
We initially gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection. However, as the registered manager was not available at that time, we inspected the following week.

Inspection activity started on 26 June 2019 and ended on 1 July 2019. We visited the office location on 1 July 2019.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from one person who used the service, the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our

inspection.

During the inspection
We spoke with the registered manager. We reviewed a range of records. This included three people's care records and medicines records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one person who used the service, two relatives and two care staff.

Requires Improvement

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 good. At this inspection this key question has deteriorated 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.

Using medicines safely
• Medicines were not always managed safely and we could not be sure people received their medicines as prescribed.
• Family members normally administered medicines. However, in February 2019 the provider had begun medicines administration for two people. Hospital discharge summaries were used to provide medicines guidelines and medicines administration records (MAR) did not have the names of the medicines administered.
• A 'To whom it may concern' letter from the GP dated 17 June 2019 noted one person's tablets may be crushed and given orally but it was not reflected in the care plan therefore it was not clear how these medicines should be administered safely.
• For one of the people, the registered manager was reordering medicines from the pharmacist and GP but this was not in the care plan. The registered manager explained it was because it was not something they had agreed to do as part of the care plan but was doing it to be helpful. They agreed to add prescription reordering and guidelines into the care plan.
• The provider did not undertake medicines competency testing of care staff but planned to when a new registered manager was employed.
• MARs were only being audited every two to three months and the last audit was April 2019. The provider anticipated a new registered manager undertaking these more regularly.

We found no evidence that people had been harmed however, due to poor medicines management, people were placed at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had a medicines policy and procedure in place.
• Three of the seven staff were nurses and only they could administer medicines, although all staff had medicines training.

Assessing risk, safety monitoring and management
• The provider did not have any moving and handling risk assessments.

We found no evidence that people had been harmed however, systems were either not in place or not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

• As the service provided palliative care, most people were discharged from hospital with assessments, for example Waterlow assessments for pressure ulcers which the service used as part of their assessment.
• The provider had risk assessments in place around falls and pressure areas which were reviewed every month or as necessary.
• The service had a policy for accidents and incidents and forms for reporting any such events were kept in people's homes so any such events could be recorded. However, there had been no incidents since the last inspection.

Systems and processes to safeguard people from the risk of abuse
• The provider had systems and processes to safeguard people from the risk of abuse.
• People and relatives said they felt safe with the care provided.
• The provider had safeguarding adult policies and procedures in place. Staff received safeguarding training to help ensure they had the skills and ability to recognise when people were at risk of being unsafe. Monthly newsletters covered different topics such as whistleblowing.
• The provider knew how to raise safeguarding concerns with the local authority where necessary and inform the CQC by sending statutory notifications. However, there had not been any safeguarding concerns since the last inspection.

Staffing and recruitment
• Recruitment procedures were in place and implemented to help ensure only suitable staff were employed to care for people using the service. After being recruited, staff undertook an induction and training prior to working independently.
• Staffing levels were adequate to meet the needs of the people using the service. Most visits were double ups attended by a nurse and a care worker to ensure people's needs were being met safely.
• Staff were allocated to geographical areas to support travel and people told us staff arrived on time, stayed for the required amount of time and called if they were running late.
• The registered manager was clear the service did not accept new packages of care unless they had the available staff and was sensitive about supporting not only the people at the end of their life but also their families. "They call us angels to help them make the transition and for me that is the most important thing. We don't just help the client, we help the family to get through it. Carers always make time to sit and talk with the family after they give care. A lot of people don't know where to get help from."

Preventing and controlling infection
• The provider had suitable procedures for preventing and controlling infection and staff had completed training in this area.
• Staff had access to personal protective equipment such as aprons, shoe covers and gloves.

Learning lessons when things go wrong
• At the time of the inspection, the provider had not had any safeguarding alerts, incidents or accidents or complaints that required changes to service delivery to be made. However, they had acknowledged they required another manager in the office as the registered manager and care manager were regularly out of the office providing care to people. At the time of the inspection they were recruiting a new manager.

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take 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 and found the provider did not always follow the principles of the MCA.

• The provider did not have records to indicate people had consented to receive the care being provided to them. The registered manager told us most people had the capacity to agree to their care but were physically unable to sign forms so their families signed instead. The registered manager acknowledged this was an area that needed improvement and would be addressing it.

Consent forms not signed by people or their legal representative meant it was not clear if people had given consent to receive care from the provider. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff told us they explained to people what they were going to do. They always let people know why they were there and asked what they wanted so care was provided to meet the person's needs on the day. Comments from people included, "They ask me what I would like to do" and "They ask what I want."

Staff support: induction, training, skills and experience
• People using the service were generally supported by staff with the skills and knowledge to effectively deliver care and support. However, the frequency of supervisions were not always in line with the provider's policy and procedure.
• The registered manager was a qualified trainer. In addition to training the provider considered mandatory,

new staff received an induction and training as part of the Care Certificate which is a nationally recognised set of standards that provides staff new to care an introduction to their roles and responsibilities.
• Staff told us they felt well trained and supported. One staff member stated, "Supervision with [the registered manager or care manager] gives me more knowledge." A healthcare professional said, "The feedback we receive from patients is that they are excellent. They can recognise changes in patient needs and their reporting is excellent. They are knowledgeable. They have managed complex, end of life patients. They have the knowledge and expertise to provide palliative care."
• The registered manager said they did not undertake any written observations or spot checks of staff because most of the time, one of the management team was working with the care worker as part of a double up at the person's house. Therefore, interaction with the care worker and person receiving the care was ongoing and any issues were addressed immediately at the time. The registered manager agreed going forward they would keep written records of sport checks.
• In addition to the management being available to people at their homes, there were monthly telephone calls to receive feedback from people using the service.
• Only two staff had worked with the service long enough to have had an appraisal and these were completed within the last year.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• All the people using the service were hospice at home referrals. Referrals were received from a local hospice and care was also funded by the clinical commissioning group (CCG). People's needs were assessed prior to agreeing to a service to ensure these could be met by the provider. This included confirming the person had appropriate equipment in their home when they left the hospital.
• People and their families were involved in pre-admission assessments which were used to form the basis of the care plan. Assessed needs included personal care and skin integrity.
• People's protected characteristics under the Equalities Act 2010 were identified and recorded in people's care plans. This included people's cultural and religious needs.

Supporting people to eat and drink enough to maintain a balanced diet
• Most people's families supported them with eating and drinking. However, care plans contained information about how people should be supported to eat and drink if required.
• Due to their circumstances most people were not eating or drinking much but if they were not eating or drinking anything staff documented it in the daily notes and informed the GP or district nurse.

Staff working with other agencies to provide consistent, effective, timely care
• The provider worked with a number of other professionals to achieve positive outcomes for people using the service. A healthcare professional said, "They provide excellent end of life and palliative care for patients at home. They are very open and honest and if they are not sure about anything, they will contact us and we will support them with any specific issues."
• The registered manager told us any changes were reported to the hospice or the CCG and there was constant communication with the district nurses.

Supporting people to live healthier lives, access healthcare services and support
• People had appropriate access to healthcare services. One healthcare professional said, "They will also call to us if there are specific concerns about client and report any changes to professionals."
• Care plans recorded people's healthcare needs and guidelines for meeting them.

Good

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.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People using the service and their relatives told us they were well treated and they had developed good relationships with the staff who were caring. Comments included, "I'm very happy with the care", "They are very pleasant and polite" and "They do give excellent care." A healthcare professional said, "The staff are very friendly and gentle to speak to. They do not rush and spend time with patients. They are just not limited to what they can do, it goes beyond to domestic tasks and patient care."
• One relative who was satisfied with the care provided said the service had previously cared for their relative at the end of their life and they were happy that the service was now caring for a second relative at the end of their life.
• The provider had an equality and diversity policy and staff respected people's cultural needs. A staff member said, "Each person is different, so we have to know their needs and family background. We have the care plan [for reference] and we write in it every day to update it." An example of respecting people's preferences was the registered manager was aware not all people liked shoes worn in their home and therefore bought shoes for staff to wear just in homes, so they could be compliant with health and safety while respecting people's wishes.
• People's cultural preferences for how they liked personal care was respected and people were given the choice of a male or female carer.

Supporting people to express their views and be involved in making decisions about their care
• People were supported to be involved in making decisions about their care. People told us, "They know what to do. They ask what I want" and "They go by what I require. They make me comfortable."
• People and staff told us staff asked people how they wanted to be supported.
• Care plans included information about people's preferences and choices and people were telephoned monthly to provide feedback.

Respecting and promoting people's privacy, dignity and independence
• People and their families were happy with the care they received. People confirmed, "They respect my privacy. So far they are very good people" and "They are respectful with personal care". A healthcare professional said, "They maintain professional values and treat patients with dignity and respect."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• At present the service did not use any communication aids. The registered manager noted many of the older people they supported did not speak English and the family acted as interpreters. Therefore, they were considering having some information translated into different languages to be more accessible to people.

We did not see evidence that people received accessible information to enable them to make decisions about their care and make their preferences known. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
• Care plans did not have information on end of life wishes.
• Due to recent training, the registered manager was aware people required an end of life care plan and was planning to implement one. At present the service followed the plan the person had when they moved from the hospital and respected any 'do not resuscitate' wishes people may have had.

Not having an end of life care plan meant people's wishes and particular preferences for care at the end of their lives were not known to staff providing care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• People told us they had choice and control.
• Care plans were developed through the initial assessment and information from other healthcare professionals. Most people received palliative care at home with their families and care plans were discussed with the person and their family so adjustments could be made to accommodate the person and the family's needs.
• Care plans were personalised and recorded people's preferences. They included assessed needs, the required action to achieve these and goals and outcomes. Family and social interest information provided staff with context and areas of interest for the person.
• Staff were knowledgeable about the needs of the people they supported, and a healthcare professional

told us, "H & B Homecare provides a person centred care plan which is agreed by us and client. They go above and beyond the client's needs".
• Care plans were evaluated daily and signed by staff to show the care and support the person had received at each visit. Reviews were undertaken as required or monthly so any changes in need were identified and addressed.

Improving care quality in response to complaints or concerns
• The provider had a complaints process and forms but had not had any complaints since the last inspection.
• People told us they knew how to complain to if they had a concern. Their comments included, "I have no complaints about them" and "If I want to make a complaint I know how." A relative said, "I have documents about how to complain but I have no reason to complain."
• People's home files contained information on how to make a complaint and included contact details for CQC, the ombudsman and local authorities. They also had a list of advocates such as Age UK and Citizens Advice Bureau with contact details.

Requires Improvement

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 good. At this inspection this key question has deteriorated 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

- The provider carried out checks and audits. However, their quality assurance systems had not identified records such as supervision and spot checks were infrequent.
- Some risk assessments were in place but there were no moving and handling risk assessments.
- Care plans did not record end of life wishes.
- The provider lacked consent to care forms and care plans were not signed by people even if they had the capacity to do so.
- The provider's spot check policy indicated spot checks should be done every three months. However, this was not happening. Additionally, the provider undertook telephone quality checks with people but only two had been completed in 2019. The registered manager explained this was because they worked alongside care staff which provided an opportunity for supervision and monitoring people's work.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- The registered manager and the care manager were both company directors. They were qualified nurses and trainers and had worked in community care for a number of years. They understood their roles and responsibilities and were involved in both managing the service and providing care to people.
- The provider was in the process of implementing a new electronic system and developing their audits and data management systems.
- Feedback from the two telephone quality checks were positive. Comments included, 'I am very happy with the carers who attend to my [relative]. They always look smart after their personal care needs are met' and 'All the carers that are caring for my [relative] are very good, friendly, compassionate and professional.'

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

- The registered manager promoted an open culture and was available people and staff. People told us they were able to make choices about their care. All stakeholders spoke very highly of the registered manager. One person told us, "[The registered manager] is very good. They know their job well."

• Staff felt supported and said "[The registered manager and care manager] are very supportive. They know exactly what to do and how to give us proper direction."
• Care plans were person centred with information about people's wishes and preferences, so staff had guidelines for delivering personalised care.

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
• The provider understood their responsibility around the duty of candour and were open in sharing information during the inspection.
• The provider had policies and procedures in place to respond to incidents, safeguarding alerts and complaints and knew who to notify.
• People and their relatives said they could speak with the registered manager if they had any concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider had established links in the community and had positive working relationships with other health and social care professionals including GPs and district nurses.
• The provider undertook annual satisfaction surveys. In 2019 they were consistently rated as 'excellent' or 'good'. Team meetings were held to give staff the opportunity to express their views and give feedback.
• As the registered manager and the care manager worked alongside the four care workers, there were regular opportunities for people using the service and the care workers to talk with the managers.

Continuous learning and improving care
• The provider was restructuring roles as the registered manager was also one of the directors and provided 'hands on care' as well as undertaking a management role. The service was expanding from palliative care to provide reablement support and the registered manager had recognised that they could not effectively manage all these areas with an increased case load. Consequently, they planned to employ a new manager who would apply to become registered with CQC.
• They had recently employed a company to update their polices and were in the process of embedding them and improving practice. They were also implementing an electronic care records system to improve their monitoring and oversight of the service.
• There was ongoing training to ensure staff had the required skills to care for people.
• The registered manager attended the local authority's provider forum, kept their nursing registration up to date and accessed on line information from organisations such as Skills for Care (an organisation that supports providers with training and development) to keep up to date with current guidance and good practice.

Working in partnership with others
• The provider worked in partnership with various other health and social care professionals. The registered manager and the local hospice confirmed they had a good working relationship. A healthcare professional said, "We communicate regularly via email and telephone call. The team is very friendly and approachable. They also answer out of hours and report to clients if they are running late."

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not appropriately meet their needs and reflect their preferences. Regulation 9(1) (a) (b) (c) and (d)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always seek consent for care and treatment from the relevant person. Regulation 11(1)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of the service users and do all that is practical to mitigate any such risks. Medicines were not managed in a safe and proper manner. Regulation 12 (1)(2) (a) (b) and (g)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance

The provider did not always assess, monitor and mitigate the risks relating to the health, safety and welfare of each service user, persons employed in the carrying on of the regulated activity or the management of the regulated activity.

The provider's audit and governance systems were not effective.

Regulation 17(1)(2) (a) (b) and (f)