Aniis Ltd

Aniis Care

Inspection report

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Date of inspection visit:
20 May 2022
23 May 2022

Date of publication:
19 July 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Aniis Care is a domiciliary care agency. It provides personal care to mostly older people living in their own homes in the Surrey area. Some people were living with dementia or with physical disabilities. At the time of our inspection the service was providing care to 21 people.

People's experience of using this service and what we found
People and relatives told us they felt people were safe. However, the provider had not always assessed risks to people's or staff members' health and well-being or done all that was reasonably practicable to reduce those risks.

We received mixed feedback from people and their relatives. Some people spoke positively about their care experiences, while others said their care visits felt rushed and they had not always experienced a caring attitude from staff.

The provider had not consistently followed safe recruitment processes to help make sure they only employed suitable staff. Medicines support was not always managed safely. The provider did not always manage records about the service and people's care appropriately.

There were arrangements in place for preventing and controlling infection, but the provider had not implemented these in line with national guidance.

There were some quality monitoring systems in place, but these had not always been effective as they had not enabled the provider to identify and address the issues we found.

Staff told us they felt supported by managers who were always available to them. The provider worked with other agencies to provide people with joined up care.

Rating at last inspection and update
The last rating for this service was requires improvement (published 20 April 2021).

At our last inspection we found a breach in relation to having effective systems in place to monitor and improve the quality of the service. The provider completed an action plan after the last inspection to tell us what they would do and by when to improve.

At this inspection, we found the provider remained in breach of regulations. At our last inspection we recommended that the provider consider current guidance on reviewing and updating people's care and risk management plans so as to assesses and support people to manage risks to their safety and well-being. At this inspection we found the provider had not acted sufficiently on this recommendation to make improvements.

Why we inspected
We received concerns in relation to the management of people's care visits. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led. We then widened the inspection to include the key question of Caring based on the evidence we found. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has not changed following this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Aniis Care on our website at www.cqc.org.uk

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed. We have found breaches in relation to safe care and treatment, medicines support, recruitment, and good governance.

Please see the action we have told the provider to take at the end of the full version of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Aniis 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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by one inspector and one 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.

Registered manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority 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 annually with key information about their service, what they do well, and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
Inspection activity started on 6 May 2022 and ended on 30 May 2022. We visited the service's office on 23 May 2022. We spoke with the branch manager as the registered manager was abroad at the time of the inspection. We reviewed a range of records, including three people's care and medicines records. We looked at four staff files in relation to recruitment and staff supervision and a variety of records relating to the management of the service, including quality assurance records. We spoke with three people and eight relatives of people who used the service. We also spoke with two care staff and three adult social care professionals who had worked with the service recently. We continued to seek clarification from the provider to validate evidence found after our visit to their office.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained 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
- People's medicines support was not always managed safely. This meant some people were at risk of not always receiving their medicines as prescribed.
- A person's care plan stated staff needed to support them with their prescribed medicines and daily care records indicated they did this. However, there was no information about what medicines staff helped the person to take and no medicines administration records (MARs) to show that staff had supported the person to take them as prescribed.
- Staff supported another person who had recently started to use the service to take their medicines. While they used a MAR to document this support, there was no information for staff in the person's care records about what the medicines were for and possible side effects.
- The provider had a system in place to assess staff competency to provide the medicines support being asked of them. However, the provider could not demonstrate that these assessments were in place for all care staff at the time of our inspection.

We found no evidence people had been harmed however, this indicated medicines support was not always managed in a safe way. 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) Regulations 2014.

- We discussed these issues with the manager so they could make improvements.
- Staff had appropriately completed the MARs we saw to indicate they had supported a person to take their medicines. Staff had completed training on how to provide medicines support safely. The provider had conducted some spot-checks on care staff in people's homes and these included the medicines support. This provided some assurance that staff supported people with their medicines appropriately.

Assessing risk, safety monitoring and management; Preventing and controlling infection; Learning lessons when things go wrong
- The provider did not always assess and manage risks to people's safety and wellbeing so they were supported to stay safe. At the last inspection we recommended that the provider consider current guidance on maintaining people's care and risk management plans appropriately. At this inspection we found the provider had not acted sufficiently on this recommendation to make improvements.
- A person's care records indicated they lived with various health conditions, but there was no assessment in the person's risk management plans of how the risks associated with these conditions affected them. There was no guidance or information for staff on how to recognise a person was becoming unwell due to their conditions and what they should do in that event.

● People's care and risk management plans were not always reflective of the care they received. For example, the manager described how two staff members needed to use assorted equipment to provide care safely to a person, but this was not set out in the person's plans. This meant staff were not always given sufficient information about risks to people's safety and how to support them to avoid harm.
● The provider did not always operate an effective system for learning from safety incidents. For example, we found a person had experienced falls at home. While these had not been witnessed by care staff, the manager reported they had not considered reviewing the person's risk management plans in response to these incidents to consider if their care needs had changed.
● The provider had arrangements in place for preventing and controlling infection, but these were not always implemented in line with national guidance.
● The provider had not completed COVID-19 risk assessments for all the people whose care records we saw. Also, the provider had not always appropriately assessed the risks COVID-19 presented to care staff. We saw the COVID-19 risk assessment for one care worker was unfinished and it didn't show who completed it or when. These issues meant the provider had not always sufficiently assessed the risks of COVID-19 to individuals' health or identified reasonable actions they could take to reduce them. We discussed this with the manager so they could update risk management plans appropriately.
● The provider informed us care staff were completing daily lateral flow tests to identify if they had contracted COVID-19, although the Government guidance at the time of our inspection only required staff to complete two tests a week. However, the provider could not demonstrate how they were assured staff had completed any tests. This meant the provider had not ensured that testing had been consistently implemented as required to reduce the risk of people contracting COVID-19 from those who cared for them. We discussed this with the manager and signposted them to relevant guidance.

We found no evidence people had been harmed however, these issues indicated risks to people's safety and wellbeing were not always assessed, monitored and managed so they were supported to stay safe. 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) Regulations 2014.

● People's risk management plans included an assessment of their home environment to consider hazards to staff and people. For example, from appliances, heaters and surfaces in a home. This included the location of fire safety equipment such as smoke alarms and how to evacuate in an emergency.
● Staff training records indicated they had completed fire safety, 'emergency situation' and basic first aid training so they could help to support people in an emergency.
● The provider gave staff information and training on infection prevention and control, including guidance about COVID-19. They had encouraged staff to receive COVID-19 vaccinations.
● The provider supplied staff with personal protective equipment (PPE) so they could support people safely. People and relatives told us staff wore PPE. The provider looked to see if staff wore this by conducting checks of staff when working in people's homes.
● Staff we spoke with told us they felt supported by the managers when incidents or accidents happened. One care worker told us, "When I have concerns I speak with them, the managers guide me on what to do."
● The manager investigated staff performance concerns when these were reported to them so as to address and reduce the likelihood of these re-occurring.

Staffing and recruitment
● The registered manager had not always operated suitable recruitment processes to make sure they only offered roles to fit and proper applicants. This is because the provider had not always completed required recruitment checks.
● The recruitment records for one care worker showed the provider had not recorded obtaining or seeking

to obtain any references from the applicant's previous employers. This information can help employers make safer recruitment decisions. We discussed this with the manager so they could make improvements to their recruitment practices.

We found no evidence people had been harmed however, these issues showed there was a risk people may receive care from staff who were not suitable for the role. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff records showed the provider had completed appropriate pre-employment checks with other applicants. These included establishing applicants' employment histories and obtaining Disclosure and Barring Service checks. These provide information including details about convictions and cautions held on the Police National Computer.
● The provider deployed sufficient numbers of staff to meet people's needs safely but we received mixed feedback about the timeliness of their care visits. Most people and relatives told us they experienced late or variable care visits. Their comments included, "Some of the timings are completely out of sync", "There are issues of timekeeping" and "It's not regular times." One relative said the provider had never given them set times for when their family member's care visits were meant to be, but the visits did take place at mostly regular times. Some people said the provider contacted them if staff were running late but some did not.
● Some people told us they felt their care visits were sometimes hurried. They said, "Sometimes they're so rushed" and "[The care worker] tends to often rush in and rush around." People said staff didn't always stay the allocated duration of their care visit. Comments included, "They don't really stay for the full time", "It feels a bit rushed, [the care worker] does what [she/he]'s got to do then doesn't hang around", and "Nobody stays the full half hour, it's 15-20 minutes if that. All they want to do is get in and out."
● At our inspection in March 2021 the registered manager told us they were sourcing a new online system to monitor 'real-time' staff attendance so as to reduce the risk of late or missed care visits. They had not implemented such a system by this inspection and the provider was reliant on care staff or people letting them know if staff were late. These issues meant they did not always operate an effective system for monitoring and reviewing missed, late or short care visits so to as identify and reduce the frequency of these from happening.
● Staff we spoke with said they usually had enough time both to travel between people's homes and to meet people's care needs during their care visits.

Systems and processes to safeguard people from the risk from abuse
● The provider had safeguarding policies and processes in place to protect people from the risk of abuse.
● The provider engaged with the relevant statutory agencies to look into safeguarding concerns when these were raised.
● People and relatives told us they felt people were safe. Staff we spoke with had received training in safeguarding adults. They told us how they would respond to and report safeguarding concerns.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
● There are times when people do not feel well-supported. We received mixed feedback from people and relatives about their care experience. Some relatives said care workers were "very polite and well spoken" and "very engaging and nice people." An adult social care professional had observed care workers had a good relationship with a person they supported and were "compassionate". Other people felt, though, they had not always experienced a caring attitude from staff or that they could develop a rapport with them. Their comments included, "[Care staff] don't really converse or anything" and "They don't really talk to me but I talk to them."
● Whilst some staff were individually kind and attentive, the provider had not ensured that this was always people's experience. A relative said they felt their family member's care could be "very 'mechanical' and "firm" because the care worker needed to work quickly. Another person told us, "The only criticism I've got is they wash me down as if I'm in a car wash. They're very firm but ease back if I tell them."
● People's care plans recorded information about their personal characteristics, including marital status and religious background. This meant staff were provided with personalised information to help them know and understand people's needs. The manager told us the service did not currently support anyone who identified as LGBT+. 'LGBT' describes the lesbian, gay, bisexual, and transgender community. The '+' stands for other marginalised and minority sexuality or gender identities.

Supporting people to express their views and be involved in making decisions about their care
● Some people or their families did not always feel actively involved in reviewing decisions about their care. A relative told us they had requested a review of their family member's care plan as it was "very bland" and "no longer appropriate" but the provider had not got back to them about this. This meant they did not always feel listened to or involved.
● Care plans set out some personalised information about people, such as their cultural preferences to be respected. These showed that people had been involved in their care assessment and planning, but a relative told us this had not been their experience.
● Service records showed the provider periodically called people or their families to check how things were going, which enabled them to comment on their care. However, some people we spoke with were reluctant to raise issues about their care service saying, "Something is better than nothing."

Respecting and promoting people's privacy, dignity and independence
● People's care plans stated when they wanted their care to help them maintain their independence and staff described how they encouraged this. A relative commented, though, that this was not always their

family member's experience, "The care package was to enable [the person] to be as independent as possible. All too often, the carer goes in and does everything for [the person]."
● People told us staff were mindful of their privacy and their dignity. Care staff described how they promoted this while providing personal care. For example, closing doors and curtains and using towels to help keep the person covered and comfortable.

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

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

At our last inspection we found the provider's audit systems for monitoring the quality and safety of the service were not operated effectively to identify and address improvements to the quality of care provision. This was an ongoing breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider remained in breach of regulations.

● The provider carried out a range of checks and audits to monitor safety and quality and make improvements when needed. However, this system of checks had not been consistently effective as it had not identified and addressed the issues we found during this inspection.
● The provider's quality assurance systems had not identified or assessed some of the risks to people's and care workers' health and well-being. They had also not ensured the provider acted to mitigate these risks. The systems had not identified and addressed issues regarding the management of people's medicines support and the safe recruitment of staff.
● The provider did not have effective systems to monitor and improve the timeliness of people's care visits and to mitigate the risk of people receiving support that was not always caring.
● The provider had also conducted satisfaction surveys with people and staff late in 2021. While the responses we saw were mostly positive, the manager told us no action had been taken yet in response to some people's feedback. For example, one comment stated, "I would love for care workers to be a little more friendly and stay the whole duration of the care call."
● The provider conducted periodic spot-checks of care workers to monitor staff performance. However, we saw the records of some of these checks, while noting no concerns, were incomplete and failed to document who undertook the checks, at which customer's homes or when the checks took place. This meant these provided only limited assurance that people received safe and effective care.
● Care staff wrote records of the support provided at each visit. However, some of the records we saw were not always clear and legible about what care was provided. One relative also remarked, "We are not convinced the note-taking is accurate. The level of information and quality of content is low." The manager could not demonstrate that these records had been checked regularly to identify and address that

improvements were required.
● These issues indicated the provider's systems had not always ensured staff maintained accurate, complete and contemporaneous records of people's care.
● We raised these issues with the manager so they could continue to make improvements.

We found no evidence that people had been harmed however, these issues indicated systems were not consistently robust enough to demonstrate safety and quality was effectively managed. This placed people at risk of harm. This demonstrated a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager demonstrated an awareness of their duty of candour responsibilities and service records showed staff had completed training on this. Some relatives told us the provider had investigated and apologised when something had gone wrong, but some said this had not happened with their issues. One relative told us, "I'm not so sure if I'd recommend the company due to the way they dealt with my complaint."
● The manager explained they were recruiting a new care supervisor and described a new service monitoring tool they were in the process of developing. They felt these would help them to better manage risks to the quality of the service and drive improvements in the future.
● Staff confirmed that the manager conducted unannounced checks on them in people's homes and they got feedback on their performance.
● The ratings for the last inspection were displayed at the provider's office and on their website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Some people said their service was good, others that it needed improvement. We received mixed feedback about the service and people's outcomes. For example, some relatives commented, "[The family member] gets reasonably good care, that's all I can ask for" and "Not quite as good as it might be."
● Adult social care professionals told us they thought people received care that met their needs.
● Staff spoke positively about the manager and working for the provider. One care worker said, "They're supportive, I've enjoyed working with them." Another staff member described the manager as "nice, really understanding and listening."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Relatives we spoke with felt involved in their family members' care and the service. One relative told us, "The communication is good."
● Service records showed the provider had called people periodically to ask them if they were happy with the care they received. This also gave people an opportunity to be involved in the service.
● The managers held staff meetings periodically to discuss the service and improvements required or being made.

Working in partnership with others
● The service worked in partnership with other health and social care agencies, such as social workers, GPs and occupational therapists. This helped people to receive joined-up care to meet their needs. For example, a relative described how staff had worked with other professionals to enable their family member to have a safe discharge from hospital.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care and treatment was provided in a safe way for service users because they did not always assess the risks to the health and safety of service users receiving care and/or do all that was reasonably practicable to mitigate such risks

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person was not always operating robust recruitment procedures to ensure that it employed fit and proper persons for the purpose of carrying on the regulated activity

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person was not always effectively operating systems and processes to assess, monitor and improve the quality and safety of the services provided in carrying on the regulated activity

The enforcement action we took:

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