Achievers Care Solutions Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Achievers Care Solutions Ltd is a domiciliary care agency providing personal care to three people at the time of the inspection. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support: It was not possible to ascertain if people were supported to have maximum choice and control of their lives due to the limited information provided. Care plans lacked detail about people's needs and preferences so we could not be confident people were always receiving the support they needed. Information about the risks people faced when receiving care was not detailed enough to ensure people received safe support. We saw from care notes that people were supported by staff to pursue their leisure interests.

We could not determine if the service made reasonable adjustments for people so they could be involved in discussions about how they received support. We asked how the service sought feedback from people receiving care but did not get a response.

Right Care: People's care, treatment and support plans did not reflect their range of needs and thus did not fully promote their wellbeing. Care was not planned in a person centred way. Records of care were not always clear. Not all staff understood how to protect people from poor care and abuse, whilst the service had not worked well with other agencies to do so.

People's families provided feedback and contributed to reviews of their care. Relatives told us they were happy with the care their family members received. From care notes it appeared people could communicate, to a degree, with staff because staff supported them consistently and understood their individual communication needs.

Right Culture: The provider could not evidence that people were supported by staff who understood best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. This meant we could not be sure people received compassionate and empowering care that was tailored to their needs.

Whilst staff and families spoke highly of the registered manager and said they found them supportive and

approachable, we found the registered manager lacked understanding of how to manage a registered service. The quality assurance and governance processes in place were not effective as they had not identified issues we found with, for example, the quality of care plans and risk assessments.

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 requires improvement (published 25 November 2019).

At our last inspection we recommended that the provider take steps to improve their assessment of risk, their management of medicines and their quality monitoring systems. At this inspection we found the provider had not taken adequate steps to act on these recommendations.

Why we inspected
This inspection was prompted by a review of the information we held about this service which included concerns in relation to the management oversight of this service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

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

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

Enforcement and Recommendations
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 identified breaches in relation to assessing and managing risk, safe care, safeguarding people from abuse, staff training and support and good governance at this inspection. We made recommendations around COVID 19 guidance and engagement with people, their families and staff.

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore 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 six 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.

This was an 'inspection using remote technology'. This means we did not visit the office location and instead used technology such as electronic file sharing to gather information, and video and phone calls to engage with people using the service as part of this performance review and assessment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not 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.

Achievers Care Solutions Limited

Detailed findings

Background to this inspection

The inspection
We carried out this performance review and assessment under Section 46 of the Health and Social Care Act 2008 (the Act). We checked whether the provider was meeting the legal requirements of the regulations associated with the Act and looked at the quality of the service to provide a rating.

Unlike our standard approach to assessing performance, we did not physically visit the office of the location. This is a new approach we have introduced to reviewing and assessing performance of some care at home providers. Instead of visiting the office location we use technology such as electronic file sharing and video or phone calls to engage with people using the service and staff.

Inspection team
This inspection was carried out by two inspectors.

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 announced. We gave 22 hours notice due to the previous unavailability of the manager.

Inspection activity started on 24 August 2022 and ended on 12 September 2022.

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 and professionals who work with the service.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used information gathered as part of monitoring activity that took place on 9 March 2022 to help plan the inspection and inform our judgements.

We used all this information to plan our inspection.

During the inspection
We spoke with the provider who is also the registered manager and nominated individual. This person currently has sole legal responsibility for supervising the management of the service. We also spoke with two carers and two relatives of the people using the service. We were unable to communicate directly with the people using the service due to their young age and capacity, but family members provided feedback about their and their loved ones' experience of care. We liaised with the local authority and reviewed a number of documents including care plans, risk assessments and daily call notes. We also reviewed policies, procedures and records relevant to the management of the service.

This performance review and assessment was carried out without a visit to the location's office. We used technology such as video calls to enable us to engage with people using the service and staff, and electronic file sharing to enable us to review documentation.

Inadequate

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. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
- The provider was not able to demonstrate they had effective systems in place to keep people safe from avoidable harm.
- The provider had failed to notify CQC about a safeguarding incident which involved the police earlier on in the year.
- Carers were able to say what action they would take if they suspected abuse was taking place but only one understood what was meant by whistleblowing.
- The provider had failed to follow registration regulation requirements and inform us they were providing services to children. We requested but did not receive the agency's safeguarding policies and procedures relating to children.
- The provider's training matrix did not include any reference to training specifically in the care and safeguarding of children.

The lack of effective safeguarding systems are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives told us they felt their children were safe in the care of the agency's staff.

Assessing risk, safety monitoring and management
At our last inspection we recommended the provider seek and implement guidance from a reputable source in relation to managing the risks to the health and safety of people. The provider had not made improvements.
- Risks were not fully assessed. Staff did not keep accurate and up-to-date records.
- Risk assessments were in place, but they did not provide adequate information about potential risks, identified risks or the management needed to mitigate them. For example, all three plans we reviewed had 'scored' the person as being at low and medium risk. This discrepancy meant carers were given conflicting information which could, in and of itself, place people at risk.
- Each person had a risk assessment but there were inconsistencies in each. For example, one said that a second carer was not needed for helping move the person, yet also stated the second carer had completed appropriate training. Another part of one assessment said carers did not take the person out in a car, yet also stated that the person was usually calm when being taken out in a car.
- The risk assessments were not person centred. We reviewed three and each one contained the same information in places. For example, although different families, all had identical hazardous substances in their home. We also saw the wrong name and gender was used.

● Neither of the staff we spoke with were aware that risk assessments were in place.
● We also reviewed a lone worker risk assessment relating to two of the people. This contradicted information in the individual risk assessments. For example, it referenced what staff should do if a person displayed behaviour that challenged; and to ensure the risk of a person wandering whilst on an outing was assessed – whereas this had not been referenced at all in the individual risk assessment.
● We read in the daily care notes that a carer had taken action that may have put the person at risk in relation to a health condition of one of the people they were caring for. Neither the risk assessment or care plan for this person made reference to the condition or action to take if the condition presented itself.

Staff did not have access to accurate information to mitigate risks to people, and were not aware of the information that was in place. These issues with the risk assessments are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We acknowledge that after we raised concerns regarding the action described in the care notes, the registered manager sent us further documentation, including an additional incident report and an investigation report. Whilst these indicate appropriate medical support was obtained, it does not allay our concerns regarding the risk assessment and care plan.

Staffing and recruitment
● We were unable to determine if staff recruitment and induction training processes promoted safety, or if recruitment had been undertaken in a satisfactory manner. We twice requested copies of staff recruitment files but they were not forthcoming.
● We were sent copies of two spot checks for one member of staff, one for May 2022, the other for July 2022. These were almost identical, for example, the same incident of the person leaving their bag on the school bus was referenced in both spot checks.
● A training spreadsheet and copies of staff induction programmes were provided. Dates on these were inconsistent. For example, one induction form said the member of staff had completed their induction in January 2021, whilst the training matrix indicated it had been undertaken in February 2022.
● We received a copy of the agency's care worker job description. This made no mention of caring for children or what experience and/or qualifications might be needed.
● Staff were vague about the training they had undergone. Whilst they felt they had had training appropriate to care for children, this was not reflected in the training information we were sent.
● One member of staff told us they had regular supervision however another told us they had not had any, although they would like some.
● From 1 July 2022, all health and social care providers registered with CQC must ensure that their staff receive training in how to interact appropriately with people who have a learning disability and autistic people, at a level appropriate to their role. There was no evidence that this requirement was being acted upon.

The lack of training appropriate to the people being looked after, and the lack of regular supervision for all staff are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had enough staff, including for one-to-one support for people to take part in activities how and when they wanted.
● One member of staff told us they had an annual appraisal, and a copy of the appraisal report was sent to us. Both staff we spoke with told us they felt well supported by the registered manager.
● The registered manager told us of plans to recruit additional carers so that there would be cover for

potential staff absences.

Using medicines safely
At our last inspection we recommended the provider refer to and implement current guidance in relation to safe medicines management.
● At the time of this inspection no staff were administering medicines. We were therefore unable to assess if the provider had acted on the recommendation.
● The agency had a medication policy in place, and the registered manager told us that she had trained staff in medicine administration which meant, she said, the agency was in a position to take on new people who might need assistance in this area.

Preventing and controlling infection
● We were not wholly assured that there were appropriate measures in place to ensure people were protected from the risks of infection.
● The provider did have an infection control policy in place. However, the section regarding COVID testing was unclear. Staff were not clear what current testing requirements were.
● Staff told us they were given appropriate personal protective equipment (PPE) to wear, and that they had access to adequate stocks.
● The registered manager told us stocks of PPE were in peoples homes and in her absence had arranged for the senior carer to distribute stock as needed. The senior carer confirmed this was the case.

We recommend the provider consider current guidance in relation to COVID testing in care services.

Learning lessons when things go wrong
● The registered manager gave us an example of learning when care had not gone as anticipated. This example related to the need to fully plan when taking people out into the community, in the event they may display behaviours of anxiety or distress. We were not assured as to the degree of learning taken, as care documentation reviewed as part of this inspection stated behaviour that challenged was a low risk. Action that might mitigate this [low] risk had not been recorded.
●Staff told us that they discussed incidents at team meetings and took learning from them. We requested copies of team meeting minutes, but these were not forthcoming.
●There had been one incident involving the police in the last year. This had been recorded however the provider had not informed CQC (as mentioned earlier in this report).

Inadequate

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. At this inspection the rating has changed to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection we recommended the provider seek and implement guidance from a reputable source in relation to quality monitoring systems. The provider had not made improvements.
- The quality assurance processes in place were not robust and had not identified the issues found during the inspection in relation to, for example, record keeping.
- We twice requested but did not receive copies of audits that had been carried out over the previous year. We were sent a grid showing what audits had been carried out and when, but the audits themselves were not provided.
- The registered manager had failed to notify the Commission that they had commenced providing personal care to children. Providing a regulated activity to his age group was not and is not part of this providers registration.
- Whilst the registered manager clearly knew the needs of the people using the service, documentation such as risk assessments were not person centred. In a number of places information had evidently been copied from one assessment to another.

The above issues are a breach of Regulation 17 (Good Governance) of the Health and Social Care Act (2008) Regulated Activities (Regulations) 2014

- The provider had failed to notify the Commission they would be absent from managing the regulated activity for a period in excess of 28 days.
- Until we requested specific detail, the provider had failed to inform us who was managing the service in her absence. We were unable to access the location to review documentation.

Failure to appropriately notify CQC of the aforementioned absence is a breach of regulation 14 (Notification of Absence) of the Care Commission (Registration) Regulations 2009

- Staff and relatives told us they found the registered manager open and approachable.
- Staff felt able to raise concerns with managers without fear of what might happen as a result.

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 registered manager told us she understood the principles of the duty of candour, and was able to describe the action that she should take and how she should communicate with people if anything went wrong.

● The above notwithstanding, the provider had failed to notify the Commission of an event in which the police were involved. This demonstrated her understanding of duty of candour was not comprehensive.

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

● Whilst we acknowledge the registered manager spoke with staff and relatives regularly, we were unable to establish how often their views were sought in a more formal manner – for example through surveys and used the feedback to develop the service.

● We asked for any analysis of feedback surveys sent to staff and relatives. We did not receive anything.

● The registered manager told us she asked for feedback via telephone. Staff told us they had completed surveys but were vague as to when.

● We asked for information to show if and how the agency obtained feedback from the children they cared for. This information was not forthcoming.

● We asked for documentation of staff team meetings. This information was also not forthcoming so we could not be sure the provider kept staff updated with changes in policy or changes within the service.

We recommend the provider consider current guidance on seeking, recording and acting on feedback.

Continuous learning and improving care

● The registered manager showed they were open to learning and improving the service, albeit they had not recognised the implications of their lengthy absence and their failure to notify the Commission of this. Once advised that this was a requirement, the Commission was informed.

●The registered manager told us they planned to implement an electronic call monitoring system, as currently all oversight of care calls was carried out manually.

Working in partnership with others

● The registered manager described close working relationships with the parents of the people using the service. This was confirmed by the parents we spoke with.

● Staff and the registered manager told us they had regular meetings via telephone, and indeed they said they spoke to one another almost every day whilst the manager was overseas.

● We received feedback from one local authority. They told us they had had considerable difficulty in contacting the registered manager, who had not responded to calls or requests to attending meetings. We fed this back to the registered manager who said that her contact details were easily available.

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 Risks to people had not been properly assessed or mitigated. Regulation 12(1)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received training appropriate to the service users they looked after. Not all staff received supervision. Regulation 18 (2)

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems to keep service users safe from avoidable harm and abuse were not always effective. Service users were not being adequately protected against the risk of receiving unsafe and inappropriate care.

The enforcement action we took:

We issued a warning notice requiring the provider to become compliant by 30 November 2022.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor, assess and improve the quality of the service were not always effective. Service users were not being adequately protected against the risk of receiving unsafe and inappropriate care.

The enforcement action we took:

We issued a warning notice requiring the provider to become compliant by 30 November 2022