Assistants at Hand (South West) Ltd

Assistants at Hand @The Pearn

Inspection report

Eggbuckland Road
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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
Assistants at Hand @The Pearn is a domiciliary care agency (DCA). The service provides personal care services to people in their own homes. At the time of our inspection 14 people received personal care.

Not everyone who used the service received personal care. 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
Risks to people were not managed safely. There were no established systems in place to monitor the quality of service. Medicines management was not based on current best practice which exposed people to a significant risk of harm and/ or not receiving their medicines as prescribed.

People were not protected against the employment of unsuitable staff as the provider failed to follow safe recruitment practices. Staffing rotas indicated there were sufficient staff to meet people's needs. However, the service did not deploy staff effectively and this had a negative effect on people's wellbeing and on occasions resulted in people not receiving their planned care visits.

Although some people and relatives told us they felt people received safe care, our findings were that people were not safe and were at risk of avoidable harm associated with their assessed care needs. The findings of our inspection identified a culture that was not based on learning. This means if and when things go wrong, the potential for re-occurrence was probable because there was no action taken to review, investigate and reflect on incidents.

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 23 January 2018).

Why we inspected
This inspection was prompted because we received concerns in relation to people's safety and the management and leadership within the 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 Good 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 Assistants at Hand @The Pearn 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.

At this inspection we have identified four breaches in relation to Safety, Recruitment, Staffing and the overall management of the service.

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

Follow up
We will continue to work with the local authority to ensure people's safety. The provider has taken the decision to de register this service.

The overall rating for this service is 'Inadequate' and the service <is therefore> / <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?

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.

Assistants at Hand @The Pearn

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 team was made up one inspector, Two Assistant 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.

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
This inspection was unannounced.

Inspection activity started on 7 February 2022 and ended on 16 February 2022. We visited the location's office/service on 7 February and 9 February 2022.

What we did before the inspection
Before the inspection we reviewed the information, we held about the service, including notifications we

had received. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales. We sought feedback from the local authority. We used this information to plan the inspection.

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.

During the inspection
We spent time with and spoke with seven people using the service, four relatives, four members of care staff, the finance officer and the registered manager. This helped us assess and understand how people's care needs were being met. We reviewed records relating to six peoples care needs and the day to day running of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with four health care professionals, a representative from Plymouth City Council's quality assurance and improvement team (QAIT) and safeguarding team and two relatives.

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

Assessing risk, safety monitoring and management

- Risks associated with people's on-going health needs, were not managed appropriately. For example, the registered manager had failed to ensure adequate risk assessments had been completed for people who were at risk of pressure care. This meant staff could not be guided in providing safe and effective care in relation to people's skin.
- One person's care plan identified that they were at risk of choking and needed assistance with eating meals. We checked the care visit records for this person and identified that on six occasions staff had failed to record that support had been given. The registered manager could not provide a satisfactory explanation as to why these visits were recorded as not taking place.
- A relative we spoke with told us "(Staff) have sometimes not followed the care plan which says (person) must not be left until (they) have finished eating because of choking risk". This placed the person a risk of significant harm.
- Where people were at risk of malnutrition and dehydration their care records guided staff to ensure that food supplements and fluid intake and in some cases fluid out take were recorded. There was a system in place to capture this information, however staff failed to follow the guidance in care plans. One relative we spoke with told us "(Person) Mum has lost weight". This meant people were at increased risk of not receiving appropriate care as and when they needed it.

Using medicines safely

- Medicines management was not based on current best practice which exposed people to a significant risk of harm and/ or not receiving their medicines as prescribed.
- There were no individualised care plans which helped guide staff to give people 'as required' medicines for pain relieving medicines. This meant, people may not have received their medicines when they needed them and could be in prolonged pain.
- Staff received spot checks from the registered manager, however these checks did not outline or record staff competencies in relation to the administration of medicines being assessed. This meant that medicines were not always managed safely and in line with The National Institute for Health and Care Excellence (NICE) guidance Managing medicines for adults receiving social care in the community.
- The system for recording administration of medicines was ineffective. Records contained gaps and errors and we could not be assured that people received their medicines as prescribed. There was no oversight of medicine administration records. This meant that medicines could not be managed properly and safely.

The concerns we identified in relation to risk management and medicines management was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

● People were not protected against the employment of unsuitable staff as the provider failed to follow safe recruitment practices. The provider failed to ensure all staff had DBS checks. A relative we spoke with told us "The young carers recently recruited were not DBS checked". Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● Providers must have effective recruitment and selection procedures in place to ensure staff are suitable to carry out their roles.

● The provider failed to follow their own recruitment policy. This meant that the necessary checks were not always completed to ensure staff were of good character and placed people at risk of receiving care from unsuitable staff. For example, the registered manager had failed to ensure all staff had references.

The concerns we identified in relation to safe recruitment was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staffing rotas indicated there were sufficient staff to meet people's needs. However, the service did not deploy staff effectively and this had a negative effect on people's wellbeing and on occasions resulted in people not receiving their planned care visits.

● On the first day of our inspection the registered manager told us there had been no missed visits. However, we noted that one person had in fact had a missed call and staff had recorded this in the person's care records.

● The service used an electronic system to record and log when care visits had been carried out. We identified 57 instances across a three-month period where care visits were not recorded for four people. The registered manager could not provide a satisfactory explanation as to why these visits were recorded as not taking place and we could not be assured that people were receiving their planned care visits.

● Relatives we spoke with told us people did not always receive their care visits as planned. One relative said, "Sometimes don't turn up". Another relative said "They don't always stay for the full allocated time". We noted one person's one hour 9am morning call was recorded as taking place at 11.46 until 11.51 and the duration of the call was five minutes.

The failure to deploy staff effectively was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Learning lessons when things go wrong

● Systems were either not in place or robust enough to demonstrate accidents and incidents were effectively monitored and reviewed.

● One person's care record identified that they had fallen three times within a month. The absence of quality monitoring systems to review care records meant the registered manager was unaware of this. This meant the health and safety of people using the service was compromised.

● This meant accidents and incidents were not effectively monitored and reviewed, because?
Staff failed to follow the services accident and incident procedures.

● The findings of our inspection identified a culture that was not based on learning. This means if and when things went wrong, the potential for re-occurrence was probable because there was no action taken to report, review, investigate and reflect on incidents.

The failure to reduce the risks relating to the health and safety of people using the service was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse

● Although some people and relatives told us they felt people received safe care, our findings were that people were not safe and were at risk of avoidable harm associated with their assessed care needs and unsatisfactory recruitment checks.

● The provider had safeguarding processes in place and we saw some examples of how the registered manager worked alongside the local safeguarding team.

Preventing and controlling infection

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured that the provider was accessing testing for staff.

● We were assured that the provider was using personal protective equipment effectively and safely.

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 Good. 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.

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

- The service was not well-led. Governance arrangements were not effective in identifying shortfalls in the quality of the service. The provider had failed to undertake any audits or quality assurance checks. This meant they had failed to identify significant shortfalls in practices including managing risk, safety and staffing.
- The provider did not have processes in place to ensure the service followed best practice guidance. For example, there was failure to follow best practice guidance for medicines management and safe recruitment practice. This meant the provider was unable to ensure people received good quality and safe care.
- There was no structured approach to monitoring the quality of care plans. There was a failure to identify that care plans did not always contain enough information and guidance to ensure safe care and support. There were inconsistencies in people's medicine records and a failure to ensure care records and information relating to people's care was accurate. This meant records could not be relied upon as an accurate record of people's care.
- People and relatives described a service which was not well-led. They told us "I have no problem with the standard of care but the management leaves a lot to be desired", "This company is poorly run and organised", "The service is not managed well" and "I consider the failure of this service is the fault of the manager".

The provider had failed to establish systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

- People's needs were not always documented in a way that supported a person-centred approach. Care plans did not always reflect people's individual preferences for how they wished their care and support to be delivered.
- Care plans did not clearly identify which aspects of their care people could manage themselves or the type of support people required in order to promote independence.
- Our findings from the other key question inspected showed that the lack of governance had not helped to keep people safe, protect their human rights and provide good quality person-centred care and support.

The provider had failed to establish systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● In the absence of a robust system to record and review accidents and incidents we could not be assured that the provider could identify incidents that required the provider to act in an open and transparent way.

The provider had failed to establish systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Continuous learning and improving care, engaging and involving people using the service, the public and staff, fully considering their equality characteristics,

● We could not be assured that a culture of learning was fully embedded because of our findings in the safe and well-led section of this report.

● During our inspection we asked if there was a system to record and act on complaints. The registered manager was able to provide a policy that supported this, however they told us that the service had not received any complaints.

● When we spoke to people and relatives, we were made aware of four instances that met the threshold of a complaint as per the provider's policy. This meant complaints had not been dealt with appropriately.

● People were invited to provide feedback on care. Relatives told us they received satisfaction surveys. People and their relatives gave a mixed response when asked if the service acted on the feedback they provided. One relative told us "I have received a questionnaire and given feedback which I don't think was acted on". Another relative said "I have received a questionnaire in the past, most of my comments have been positive and any issues sorted".

The provider had failed to establish systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Working in partnership with others

● Whilst we saw some examples of where the registered manager and provider worked closely in partnership with healthcare professionals. We also could not be assured that partnership working was fully embedded because of our findings in the safe section of this report.

● Although we saw evidence that sometimes advice was sought from healthcare professionals, we saw examples that people's care records did not always contain information relating to their assessed needs.

● One person's care record reminded staff that a person was under The Speech and Language Therapists care. However, there was no other records relating to what recommendations had been made to keep the person safe. Therefore, we could not be assured that recommendations by healthcare professionals were always followed up and/or actioned.

The provider had failed to establish systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 concerns we identified in relation to risk management and medicines management was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to reduce the risks relating to the health and safety of people using the service and The providers failure to establish systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The concerns we identified in relation to safe recruitment was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The failure to deploy staff effectively was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014