Anco Care Services Limited

Anco Care Limited

Inspection report

117 Langcliffe Drive
Heelands
Milton Keynes
Buckinghamshire
MK13 7LD

Tel: 01908315261

Date of inspection visit:
26 June 2023
27 June 2023

Date of publication:
09 August 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Anco Care Limited is a domiciliary care agency providing personal care to people in their own homes. At the time of our inspection there were 4 people using the service.

People's experience of using this service and what we found
This service has been rated inadequate in well-led on 5 occasions since 2019. The provider has not been able to implement, embed and sustain effective governance and oversight of the service. We found continued concerns about the quality of systems and records. The provider could not assure themselves people received safe care due to the lack of effective processes in place.

Quality assurance audits remained ineffective at identifying and driving improvement. This included in areas such as medicines, accident and incident recording and safeguarding processes, all of which potentially impacted upon people's safe care and treatment.

Not enough improvement in people's care records including risk assessments, care plans and mental capacity assessments had been made. There remained gaps, inconsistencies and unassessed areas of known risk. There was no overall service improvement plan to set out the actions identified and underway to make, embed and sustain improvements.

Medicines processes remained unsafe. Recording of medicines administration was inaccurate. There was no guidance to support staff safely administer some 'as needed' medicines. Medicines audits did not identify any concerns.

Not all known risks were identified or assessed. Concerns with risk assessments were found in the last 5 inspections and remained ongoing.

Accidents and incidents were not always recorded. Due to this the provider could not assure themselves appropriate actions were always taken, including learning lessons to reduce the risk of recurrence. Safeguarding referrals were not always made when required.

People's eating and drinking needs were not always assessed or accurately recorded. This included when people were at heightened risk of choking and required physical assistance with eating and drinking.

When people's capacity fluctuated, processes to assess their capacity and make decisions in their best interests were not effective. Issues identified at the last inspection had not been fully rectified in this area. People remained at risk of having decisions made which were not in their best interests or in line with their wishes.

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 always support this practice.

There was no easy reference system to check whether staff training was in date, and the chart showing staff training contained gaps. People were potentially receiving care from staff who did not have all required training.

Care plans did not contain sufficient detail to guide staff in people's routines, needs and preferences.

People and relatives felt safe care was provided. Safe recruitment processes were followed. Staff were reliable. Staff used personal protective equipment (PPE) to reduce the risk of any infection spread.

Staff told us they received an induction and feedback confirmed people and relatives felt staff were competent in their roles.

People and relatives told us they were involved in making decisions about their care. People received support from staff who were caring, kind and attentive. People's privacy and dignity was respected, and their independence was promoted.

The provider and staff worked with health and social care professionals to ensure people received timely health care and support.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement and there were breaches of regulation in the areas of people's safe care and management oversight. We issued a Warning Notice to give the provider a short timescale to make improvements. Due to repeated ratings of requires improvement, the service was placed in Special Measures.

At this inspection we found the provider remained in breach of regulations in relation to people receiving safe care and treatment. We also found a continued breach in provider oversight of the service.

Why we inspected
We undertook this focused inspection to check whether they had met the Warning Notice in relation to management oversight and the Requirement Notice about people's safe care.

We inspected and found there was a continued concern with mental capacity assessments and staff having access to sufficient information to ensure people were fully involved in decision making. We widened the scope of the inspection to become a focused inspection which included the key questions of safe, effective, caring and well-led.

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 at this inspection.

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

Enforcement and Recommendations

We have identified continued breaches in relation to people receiving safe care and management oversight at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Following the inspection the provider submitted an action plan outlining planned improvements.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Anco Care Limited

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 2 inspectors.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We 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.

Inspection activity started on 26 June 2023 when we made phone calls to people and relatives of people who used the service. We visited the location's office on 27 June 2023 and reviewed documents remotely afterwards.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the

information the provider sent us in the provider information return (PIR). 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 this information to plan our inspection.

During the inspection
We spoke with 1 person and 2 relatives of people who received support for feedback on their experience of the care provided. We spoke with the registered manager, manager and 4 staff. We also received email feedback from 8 care staff. We reviewed a range of records. This included 4 people's care records and medicine records. We looked at 2 files in relation to staff recruitment and support. We looked at a variety of records relating to the management of the service.

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.

Using medicines safely

At our last inspection the provider had failed to maintain accurate and up to date records about medicines for people receiving medicines support. This placed people at risk of harm. This was a breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Medicines administration and recording remained unsafe. Records of people's medicines administration were inaccurate. No recording of 1 person's medicines administration took place and at the time of inspection staff administered their medicines 3 times per day. This raised the risk of misadministration and potential side effects from this.
● When people received medicines 'as needed' (PRN) there was insufficient guidance to ensure staff knew how, when and in what circumstances to administer it. One person was prescribed morphine, a strong pain killer, but there was no guidance for staff to ensure it was given correctly and safely.
● An electronic system had started to be used to record medicines administration. Recording for 1 person was inaccurate and contained many gaps. This raised the risk of the person not receiving their medicines as prescribed.
● Audits of medicines were ineffective. Issues were not identified or rectified.

Systems had not been improved to ensure medicines records and oversight was accurate and up to date. This placed people at ongoing risk of harm. This was a continued breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse
● Risk assessments did not record that all known risks to people's care were identified, assessed and monitored. For example, some people were at increased risk of choking, pressure wounds or falls and there were no risk assessments in place. This meant staff did not have guidance on how to mitigate the risks as far as possible. This increased the risk of unsafe care or care which did not meet people's needs.
● When equipment was used to support people's safe care, this was not always assessed. For example, a safety strap used when 1 person used a wheelchair. Two people used bedrails to support their safety but there was only a risk assessment in place for 1 person. There was inconsistent information about the equipment needed to support 1 person transfer or mobilise. This placed people at higher risk of receiving

unsafe care if equipment was used inappropriately.
● At the time of inspection 2 people required physical assistance with eating and drinking and were at heightened risk of choking. One person required pureed food and sometimes thickened drinks but this was not mentioned in their care plan. The provider could not assure themselves staff had sufficient information to ensure people's nutritional needs were met safely.
● The need for improvements in risk assessments was identified as an issue in the last 5 inspections. This was not fully addressed which meant people remained at risk of receiving care which was not assessed to be safe.
● Accident and incident reporting processes were not always effective. There was no record of some incidents. This meant the provider could not assure themselves that appropriate action was always taken at the time.
● Due to the lack of accurate records, the processes to learn lessons when things went wrong and share these learnings with the staff team were not robust. This raised the risk of the same or similar things going wrong again.
● Safeguarding referrals were not always made when people were placed at risk of potential harm. For example, due to a miscommunication care staff had not visited to support a person with their morning routine, which was essential. This placed them at potential risk of harm but the local authority were not notified. This meant an assessment did not take place of what went wrong and how the risk could be reduced in future.

Risks to people's safe care and treatment were not always assessed, monitored and reviewed. Safeguarding processes were not always followed. Accident and incident processes, and systems to learn lessons when things were ineffective. This placed people at an ongoing risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives told us they felt staff provided safe care to people. One relative told us, "I've very happy. I know [family member] is safe."
● When people's needs and risks changed the provider was flexible and accommodating. One relative said, "[Registered manager] said she was worried about my [family member]. I said I didn't know what to do for the best. We came up with a plan which is working. The communication is amazing."

Staffing and recruitment
● The provider followed safe recruitment practices. This meant checks were carried out to make sure staff were suitable and had the right character and experience for their roles.
● Staff were reliable, usually arrived on time and stayed for the full length of the scheduled visit.
● People received support from a small team of staff. Several new staff joined the service recently so some people and staff were still getting to know each other. The manager intended for each person to receive support from a small and consistent team, which they were working towards.

Preventing and controlling infection
● Staff used personal protective equipment (PPE) such as masks and aprons when supporting people with personal care. This helped reduce the risk of any infection spread.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

● Care records did not contain sufficient detail about the support people needed to ensure they ate and drank safely. When people's food and fluids were recorded to assist with monitoring their intake, these were not always accurate.

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 MCA 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.

● At the last inspection it was identified there was no mental capacity assessment or record of best interest decision for someone who used bedrails and had fluctuating capacity. This placed the person at risk of having decisions made which were not in their best interests or in line with their wishes, which was brought to the provider's attention. At this inspection we found the documentation put in place was not completed fully or effectively.

● Staff told us, and daily records showed, consent was sought before care was delivered to people. Staff knew how to support people make everyday choices when their ability to make decisions varied at different times.

● One relative told us, "Yes they always check consent, they ask [family member] all the while."

Staff support: induction, training, skills and experience

● Records of staff training contained gaps and were undated so there was no easy reference system to know whether training remained in date or had lapsed. This meant people were potentially receiving care from

staff who had not completed all necessary training.
● Staff told us they received an induction when they joined the service which included training courses as well as shadowing experienced staff. One person told us, "The new staff come 3 times with someone else before they're allowed to come on their own."
● People and relatives told us staff had the skills and competence to perform their roles well. The relative of 1 person who required support to move safely told us, "The 2nd carer comes and they do it perfectly. I know they will do it safely. I'm relieved."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care needs were set out in care plans. People and their relatives were involved in discussing, agreeing and reviewing the support they received. Care plans lacked detail in some areas which raised the risk of people receiving inconsistent support by staff not having access to enough information.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with health and social care professionals to support people's health needs. For example, district nurses and GPs.

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.

This key question was last inspected in September 2019. At that time we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care

- People's care records did not contain detailed information about their routines, needs and day to day preferences. For example, how they liked to be supported with personal care including washing and dressing or what their preferences around eating, drinking or their night time routine were. This meant staff may not be offering people appropriate choices or following the routine they preferred.
- The provider visited people or contacted them by telephone to gain feedback on the care provided, and discuss any changes needed. These communications were not always recorded to ensure all staff were aware of people's up to date feedback and views. Reports were available from visits undertaken by senior care staff.
- People and relatives told us they were involved in making decisions about their care and were satisfied with the support offered by staff.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People and their relatives were treated with respect and kindness. One relative told us, "Staff are so nice, such caring people. When I walk in they give me a cuddle and say, 'It's nice to see you.' I don't know what else to say, there's nothing they could do better."
- Staff were attentive to people's needs and were caring in their approach. This was confirmed in feedback. One relative told us, "The carers all feel like family. [Family member] absolutely adores all of them."
- People's privacy and dignity was respected. Some staff recorded details in daily notes which showed the approach they took. For example, closing the curtains before starting personal care, covering a person up on their way to the shower, and confirming dignity was maintained throughout the visit.
- People's independence was promoted by staff, supporting people to ensure they were able to do as much for themselves as they were able to and wanted to do.

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 inadequate. The rating for this key question has remained 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; Continuous learning and improving care

At our last inspection the provider had failed to ensure robust oversight and governance of the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Under this provider, this is the fifth occasion a rating of 'Inadequate' has been awarded in the key question of 'well-led' since 2019. The provider has not been able to implement, embed and sustain effective governance and oversight of the service.
● Concerns identified at the last inspection remained ongoing. A new electronic system had been introduced but the provider's oversight of this was not effective. For example, the provider undertook audits of daily notes in batches, sometimes more than 60 were recorded as audited at the same time. Issues including the lack of any notes being recorded for some visits, and one sentence being recorded on other visits, were not identified.
● Quality assurance audits did not identify the issues we found in a range of areas impacting upon people's safe care and treatment. The provider had not identified that not all accidents and incidents were recorded, and safeguarding processes were not followed when required. The provider could not assure themselves that people received consistent and safe support.
● Oversight of medicines was ineffective which had not been identified. Audits did not pick up issues including medicine administration records (MAR) being completed on days which didn't exist, for example 29th to 31 February, or being signed by staff who were different to those on shift.
● The provider had not made sufficient improvements to people's care records including risk assessments, care plans and mental capacity assessments. Concerns were brought to the provider's attention at the last inspection, but systems had not been implemented to ensure improvement actions were made, embedded and sustained.
● Concerns at the last inspection about assessing people's capacity and undertaking best interest decisions when required had not been resolved. The processes which were put in place were ineffective and the documentation was incomplete. People remained at risk of having decisions made which were not in their best interests.

● The training matrix was incomplete, courses were undated and did not include all staff. This raised concern about the provider's oversight of staff training and whether all staff had completed all required training for their roles.
● The registered manager was also the nominated individual and provider. The nominated individual is responsible for supervising the management of the service on behalf of the provider. This meant there were no other persons involved or accountable for strengthening the oversight of the service or driving improvements.
● There was no service improvement plan in place to support the provider record, prioritise and track improvements.

We found no evidence people had been harmed, however, systems and processes to oversee the quality and safety of service provision remained ineffective. This was a continued breach of Regulation 17(1) 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
● Staff provided positive feedback about their roles at Anco Care and the support they received from the provider. One member of staff said, "I believe that Anco Care is well-run and focused on delivering high-quality care." Another told us, "The management team are approachable, supportive and also respond to staff when there are concerns."
● People and relatives told us they had confidence any arising issues would be resolved promptly. We heard examples where this had happened.
● The provider was keen to keep working hard to make and embed improvements in the service. They had stepped back from care delivery in order to focus on running the service and had employed a part time manager to support with this.

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 was aware of their responsibility to be open and honest when something went wrong, in line with their responsibilities under the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People and their relatives had opportunities to discuss and provide feedback on the service they received.
● Team meetings took place and staff told us communication between the management team and staff was effective and helpful. Team meetings, along with supervision sessions, provided opportunities for staff to discuss their roles and any support needed.
● The provider and care staff worked with health and social care professionals involved in people's care and treatment.