Annies Homecare Services Ltd

Annies Homecare Services Ltd

Inspection report

Lower Farm
Steeple Road
Mayland
Essex
CM3 6EG

Tel: 01621773672

Date of inspection visit:
12 October 2022
14 October 2022
17 October 2022

Date of publication:
10 November 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Annies Homecare Services is a domiciliary care agency providing care to people living in their own houses and flats. 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. At the time of the inspection there were 39 people receiving personal care.

People's experience of using this service and what we found
The provider had not always ensured there were enough staff available to support people appropriately. People experienced missed and late care visits and staff did not always stay for the agreed length of time. The provider had not always kept people updated about delays and changes to their care.

People's medicines were not always managed safely and the provider's processes for checking the accuracy of people's medicines records were not robust. Risks to people's safety were assessed. However, the documentation in place about how people should be supported to manage these risks was not up to date or accurate.

The provider did not have effective systems in place to monitor the quality and safety of the service. The processes in place had not highlighted the concerns we found during the inspection and we could not be assured the provider had clear oversight of the service.

The employment checks for new staff were not always completed robustly. We have made a recommendation about the provider's recruitment processes. We received mixed feedback about staff's use of personal protective equipment [PPE]. We have made a recommendation about the provider's oversight of infection prevention and control processes.

People's relatives told us they did not always feel involved in the service and were not always confident their concerns would be responded to promptly. We received mixed feedback about the effectiveness of the culture and leadership of the service.

Staff were aware of how to keep people safe from harm and had received training in safeguarding. However, the provider did not have robust processes in place to analyse incidents and share any learning with staff in order to minimise the risk of a reoccurrence.

The provider worked in partnership with other health professionals in order to support people's needs. Staff told us they generally felt comfortable raising concerns with the management team and were supported in their roles.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 30 July 2018)

Why we inspected
We received concerns in relation to people's safety, staffing, the management of medicines and the provider's oversight of people's care. 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 requires improvement 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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Annies Homecare Services 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 people's safety, the management of medicines, staffing and oversight at this inspection.

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

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Annies Homecare Services Ltd

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 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.

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 we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 12 October 2022 and ended on 17 October 2022. We visited the location's office on 12 October 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. 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 seven relatives about their experience of the care provided to people who used the service. We also spoke with eight members of staff including the registered manager, manager, senior carers and care staff.

We reviewed a range of records. This included seven people's care records, three staff files in relation to recruitment and a variety of records relating to the management of the service.

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 good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- People had experienced missed and late care visits and this had not always been promptly identified by the provider. People and their relatives were not always kept updated about delays and changes to their care visits.
- People's relatives told us they did not feel there were enough staff available to meet people's needs. This impacted on the quality and length of their care visits. Comments included, "They do not have enough staff to provide appropriate care. [Person] doesn't always get their full time, some [staff] are in and out in 10 minutes," "[Person] does not get their full time due to a shortage of staff" and "[Person] never gets their full time."
- One relative told us the provider had not always ensured two staff were available to attend visits where the person required two staff to support them with their personal care.
- We received mixed feedback from staff about the number of staff available and their deployment. Comments included, "Staff shortages have a massive impact. [Registered manager] tries their best but it's difficult when there's sickness" and "It's a daily thing with the rotas changing and it can be difficult. The clients would like set staff."
- The provider did not have an effective process in place to monitor people's care visits to ensure they were taking place at the agreed time and for the agreed duration. This meant there was a risk people may be left without support in a number of essential areas such as personal care, support with medicines and assistance with meals and drinks.

The provider had failed to ensure there were sufficient numbers of staff available to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The provider had processes in place to ensure staff were safely recruited. However, not all applicants had a full employment history documented in line with guidance for safe recruitment of staff.

We recommend the provider reviews their processes to ensure all information required to safely employ staff is in place

- Staff were supported to undertake relevant training as part of their induction. Staff told us they were also given the opportunity to shadow more experienced workers prior to supporting people alone.

Using medicines safely; Assessing risk, safety monitoring and management

● The provider had not always ensured people received their medicines safely.
● We received feedback about the timing of people's care visits impacting on the safe administration of medicines. For example, visits not being spaced adequately to enable medicines to be given at the correct intervals and missed calls resulting in people not receiving their medicines on time. This increased the risk of medicines not working as effectively and may impact on people's health and wellbeing.
● People's medicines records were not always collected regularly from people's homes and this meant the management team were not able to review them to ensure no errors had been made. During the inspection, we found recording errors on one person's administration record for an important medicine, which had not been identified by the provider.
● Risks to people's safety were not always appropriately managed. People's risk assessments were not always up to date and did not reflect their current needs. For example, we found a risk assessment which had not been updated to reflect a change in a person's mobility and one which had not been updated to reflect a change in how a person was supported to receive their medicines. This meant there was a risk staff may not have accurate guidance in place to support people safely.

The provider had not ensured effective systems were in place to manage people's medicines safely and risks to people's safety were not appropriately managed. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 Mental Capacity Act (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 found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Preventing and controlling infection
● The provider had an infection prevention and control policy in place for staff to follow and staff had received training in safe infection prevention and control practices. However, we received mixed feedback about whether staff were using appropriate personal protective equipment [PPE] when providing care. Comments included, "They have always worn full PPE when I am there," "During lock down they wore masks but did for a while stop wearing them," and "They do wear gloves but tend not to wear masks all of the time."

We recommend the provider reviews staff practice to ensure it is in line with their policy

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The provider kept a record of the safeguarding notifications raised. However, investigation outcomes were not always documented and this meant it was not always clear what actions the provider had taken to minimise future incidents.
● The provider told us they shared information about incidents with staff via team meetings and

supervisions. However, there were no minutes recorded for their team meetings and the supervision notes viewed lacked detail. This meant it was difficult to evidence how lessons learnt were being discussed.

- Staff had received safeguarding training and understood the importance of raising any concerns.

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 good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The provider's systems for monitoring the quality and safety of the service were not effective and had failed to identify the concerns we found during the inspection.
- The provider did not have a robust system in place to ensure they maintained oversight of staffing levels and the deployment of staff. There was no process in place to review missed or late care visits. The provider had not identified or addressed the issues people's relatives raised about staffing levels during their feedback to us.
- The provider did not have an effective medicines auditing process in place to enable them clear oversight over the safe management of people's medicines
- The provider completed a monthly management audit which included a review of people's care plan and risk assessment information. However, this had failed to identify care plan and risk assessment documentation which was out of date and inaccurate.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider did not always have effective processes in place to gather feedback from people and their relatives. The registered manager told us they sent out an annual satisfaction survey; however, some people's relatives told us they had not been contacted. Comments included, "We have not been contacted for feedback or if we require any changes," and "I have never been asked for feedback."

All of the above demonstrated the provider did not have effective systems in place to monitor the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We received mixed feedback about the leadership and quality of the service. Comments included, "I don't think it is a well-managed service. It needs to improve as they are so short of staff and they never pass on messages from the carers. I would not recommend this agency to anyone else," and "The service requires improvement."
- Staff told us they generally felt supported and able to raise concerns with the management team. One member of staff said, "They're quite supportive, I can ring if I have an issue and they'll sort it."

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 responsibilities in relation to the duty of candour and the need to be honest with people and their representatives.

Continuous learning and improving care; Working in partnership with others

● The provider was in the process of introducing an electronic care planning and call monitoring system. They told us this would improve the quality of people's care by enabling the provider to have a real time view of the care being delivered. However, at the time of the inspection this had not yet been implemented.

● The provider had worked in partnership with a number of different health professionals in order to support people's needs including the local hospice and primary healthcare services such as the G.P. and pharmacy.

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 provider had not ensured effective systems were in place to manage people's medicines safely and risks to people's safety were not appropriately managed. This 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 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of staff available to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 provider did not have effective systems in place to monitor the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice