Allwell Care Company Ltd

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

Summary of findings

Overall summary

About the service
Allwell Care Company is a domiciliary care service providing personal care to people in their own homes in Ipswich and surrounding area. 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 this inspection there were 26 people using the service who were in receipt of personal care.

People's experience of using this service and what we found
Relatives told us that staff were often late, with some people being left until almost midday to be supported. Staff did not always support people for the length of time that had been previously agreed and people felt rushed.

Medicines were not managed in a safe way and we found significant gaps or omissions in these records. We could not be confident that people were receiving their medicines as prescribed. The risks to people from receiving support or their medicines at a different time had not been adequately assessed and relatives told us that this impacted on their family members wellbeing and health.

Risks to people's safety and wellbeing were not always identified or escalated promptly to reduce the risk of harm. There was a lack of guidance for staff on how to manage risk which was compounded by a lack of oversight.

Recruitment processes were not robust. Recruitment checks had not been completed on all new staff to check their suitability or competence to work with people prior to commencing employment. There were gaps in staff training and knowledge in key areas such as safeguarding, and we were not assured staff would recognise and respond to abuse.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

We found that staff had not had training in learning disability and autism or were clear about their roles and responsibilities in relation to the Mental Capacity Act (2005). People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests.

Since the last inspection the provider had been receiving support from the Local Authority to make improvements. Despite this quality and safety monitoring processes had not been embedded, which meant

when the previous manager left, they had not been continued and the provider had failed to identify the shortfalls we found.

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 (published 17 June 2022). There were breaches of regulation. The service has deteriorated to inadequate. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe, effective and well led.

The overall rating for the service has deteriorated to inadequate.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this 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 Allwell Care Company on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to staffing, safeguarding, recruitment and the management oversight of the service 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.

Follow up
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 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 always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Allwell Care Company

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
This 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 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 not a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and office staff are often out and we wanted to be sure there would be staff to speak with us.

Inspection activity started on 25 January 2023 and ended on 3 February 2023. We visited the location's office on 25 January 2023 and 3 February 2023. As part of the inspection we carried out phone calls to people, their relatives and staff.

What we did before the inspection

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.

What we did before 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.

During the inspection
During our on-site visit which took place on the 25 January 2023 and 3 February 2023 we reviewed a range of records. This included people's care records including medication records. We looked at 5 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We spoke with both directors including the nominated individual who is responsible for supervising the management of the service on behalf of the provider. We also spoke with 13 relatives by telephone about their experience of the care provided. We also spoke with 5 members of care staff and the new manager who was appointed part way through the inspection.

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.

Staffing and recruitment

At our last inspection the provider had failed to ensure that staff were available to meet people needs in a timely way. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, (Staffing.)

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

• Staff were not effectively deployed, and people did not always receive the support they required. People told us that timings were poor, and they were sometimes left until nearly midday to be assisted out of bed. One person said, "It can be as late as 11.45 for the first call." Another said, "A couple of weeks ago they were late getting my relative up, then they came for lunch at 3.20pm and another came at 4pm to put my relative to bed."
• There was a call monitoring system which would confirm staff arrival and record when they left however this was not used by the provider to enable effective monitoring to take place.
• People told us that they did not know when staff were coming and when they did, they were often in a rush and did not stay for the allotted time. Comments included, "They refuse to help [my relative] onto the commode because they say that it takes too long, and they say they have to use pads." "We never know who is going to come and just random carers turn up and don't always know what to do." "They rush through what they are doing just so they can escape quickly."
• Staff told us that they did not have enough travel time and they were often delayed, "We have to cut calls, we know the calls we can cut."
• We undertook call analysis and found that 28% of calls were short and staff delivered less than half the time planned. Some staff were logged at two people's homes at the same time and only 64% of calls were delivered on time. On the day of our inspection we observed that one call was running up to 78 minutes late and another 74 minutes.
• Staff did not receive the training needed for the roles they were employed to perform including having their competency assessed. New staff were commenced their role without receiving moving and handling training.

The shortfalls are a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not follow safe recruitment processes as they had not obtained a full employment history

when recruiting new staff and gaps in employment were not explained.
● Two suitable references had not been obtained for all staff prior to staff commencing work. There was no evidence that alternative references had been sought. This meant the provider did not follow their own recruitment policy or adhere to regulations to ensure that people employed were suitable.
● For newly employed staff there was a lack of evidence of induction training or competency checks in areas such as the safe administration medicines and moving and handling. Therefore, the provider could not assure themselves that staff were safe to work with people who used the service.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safe recruitment, training and support. This was a breach of Regulation 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People told us that they did not always receive their medicines on time as carers were often late. The systems in place did not take account of the importance of people receiving their medicines at the time prescribed for pain or conditions such as Parkinson's and Diabetes. One relative said, "My relative is meant to have their tablets in the mornings and sometimes they don't get them until well after 11 and then my relatives shakes without them." We saw that one person whose medicine was time sensitive was receiving calls over an hour late.
● We reviewed a sample of medicine's administration records (MAR) which had been returned to the office. We found significant gaps or omissions in MAR charts which meant we could not be assured that people received their medicines as prescribed.
● Care plans and MAR charts were contradictory about the administration of people's medicines and the role of staff. Handwritten entries on MAR charts did not consistently log the frequency or strength of people's medicines which increased the likelihood of errors. Where people's medicines were not available, we could not see any clear system in place for follow up or escalation. Staff recorded 'Not available at the moment'.
● Not all staff employed had been trained to administer people's prescribed medicines safely with their competency to do so checked.
● There was a lack of guidance for staff which would describe the reasons medicines had been prescribed, and any information which would alert staff to adverse reactions.
● There were no recent management audits which would identify medicines errors and ensure people had received their medicines as prescribed. This posed a risk to people because the registered manager did not have the oversight needed to be able to pick up on potential medicines errors.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management, learning lessons when things go wrong
● Risks to people's safety and wellbeing were not always identified or acted upon to reduce the risk of harm. We saw that one person had developed a pressure ulcer. Staff had recorded that there were skin blisters but did not escalate this to enable the person to access treatment.
● There were no clear systems in place for escalating concerns when carers were unable to access people's homes. We saw staff were recording that people were not answering the door but there was no follow up or escalation. A relative told us, "There was a note in the book saying no one at home but of course my relative was there. They just left without even trying, they might have been on the toilet or something. If they had a fall or had been taken ill no one would have noticed for hours as they just went off."
●Risks to people's safety and wellbeing had not always been assessed with guidance provided for staff to

reduce the risk of harm. We saw that they were supporting one person who was diabetic with their insulin and were recording blood sugars levels, but no guidance was provided about what actions staff should take should there be a significant variation, or their health deteriorated.

The systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- People who used the service could not be assured staff would recognise and respond to abuse.
- Staff we spoke with told us they had training but the actions they told us that they would take did not follow the services policy or local safeguarding procedures. One member of staff told us that if they observed abuse, they would ask the person why they were doing it and try and find out the reason behind it. Another told us that they would speak to the provider and "It was up to them."
- Care plans did not provide guidance for staff in the safe handling and safeguarding of people's money when carrying out shopping tasks.

Safeguarding systems were not robust. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- The provider had arrangements in place for preventing and controlling infection.
- Staff confirmed they had access to personal protective equipment (PPE). People told us that staff wore gloves and aprons when providing personal care.

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 good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Training for staff, supervision and the monitoring of staff performance was not effective. The provider had employed a trainer who had undertaken some training, but they had not been in work for some time and had not been replaced. New staff were continuing to be employed and had not been provided with training including practical training in moving and handling.
- While some new staff had shadowed more experienced staff to learn about people and their needs this was not consistent. There were gaps in training in areas such as the Mental Capacity Act and Learning Disabilities.
- People and their relatives did not have confidence in the skills of care staff. One person told us, "They are simply not skilled enough for the job."
- Supervision or appraisal was not undertaken with staff to discuss their performance and identify any training support needs. Spot checks to monitor staff performance were not being undertaken in a systematic way and in line with the providers policy.

The provider had failed to ensure that staff were trained and competent. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, (Staffing.)

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- 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. However, care and risk management planning did not include an assessment of people's mental capacity.

● The majority of staff had not been provided with training in understanding their roles and responsibilities in relation to the Mental Capacity Act (2005).
We recommend that assessment processes are strengthened to identify whether people have capacity and whether best interest decisions are required.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Relatives told us that their family members were supported by different staff which meant that there was a lack of consistency and concerns were not always escalated. Variation in call timings meant that people were not always supported to be ready for health appointments.
● Care plans outlined the professionals who were involved in the wider care and support of the person. We saw that the service made referrals to health professionals such as the continence service.
● Staff told us they would report any concerns in relation to the person's health to the management team. There was an on call service which operated out of hours, but this was not documented so there was no record of how concerns were dealt with.

Supporting people to eat and drink enough to maintain a balanced diet
● Support was provided with meal preparation as outlined in people's assessment. Most meals prepared were either sandwiches or heated microwave meals.
● Care plans contained only brief information where staff provided support to people with food preparation and eating and drinking. For example some care plans for people with diabetes, stated low sugar but not others and there was very little detail provided on how staff should support people to maintain a balanced diet.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care plans were in place but some lacked detail. Staff had a good understanding of people's needs but without written guidance there was a risk that people's needs may not be met.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; ; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Continuous learning and improving care

At our last inspection the provider had failed to ensure that systems were established and operated effectively to ensure compliance with the requirements, which was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.
At this inspection we found that sufficient improvements had not been made and the provider remained in breach of the regulations.

● There was no registered manager in place and the service was being managed on a day to day basis by the nominated individual who also worked as a member of care staff. A new manager was appointed during the course of the inspection.
● Since the last inspection the provider had been receiving support from the Local Authority. Despite this quality and safety monitoring processes had not been embedded, which meant when the previous manager left, they had not been continued. The provider had failed to identify the shortfalls we found such as poor records management, a lack of robust risk management, and a lack of training and guidance for staff.
● Relatives did not have confidence in the management of the service. Comments included, "It is all very slapdash", "It is not well managed as it is just chaos, especially with the timings of calls." "I have phoned the office to ask why they are so late always, but I never get a proper answer." "I find the office staff friendly, but no one ever gets back to me."
● The provider did not have effective systems and processes in place to ensure they had a good oversight of the service. The documentation staff completed in people's homes and on the electronic system was not detailed or reviewed on a regular basis to identify risks and keep people safe.
● Concerns and complaints were not robustly investigated. We saw in records that a concern had been raised seven weeks prior to the inspection but the provider was not able to provide us with evidence that these concerns had been investigated.
● Not all staff had received training relevant to their roles. Staff had not received training in the Mental Capacity Act and the provider was not able to evidence that all newly appointed staff had received moving and handling training from a member of staff with a recognised qualification.
● Spot checks to check on staff performance were not being planned or undertaken regularly. We could not see evidence that staff had access to supervision, annual appraisal and staff meetings to discuss their performance, identify and plan their training needs.

● There was a system in place for out of hours support but no records were maintained and therefore was no oversight or monitoring of this which had the potential to put people's health, safety and well-being at risk.

Systems were either not in place or robust enough to demonstrate effective oversight and governance of the service. This was a continued 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

● The provider was not clear about what needed to be notified to the Care Quality Commission and we identified notifications such as safeguarding concerns which had not been made as required.

● The provider told us that they understood the need to be open and transparent and acknowledged that improvements were needed to how the service was managed. They cooperated with requests for information in a professional and open way.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, Working in partnership with others

● The majority of relatives we spoke with were not satisfied with the service that their family member was receiving. Some spoke positively about individual members of staff, who they described as helpful, but most would not recommend the service to others.

● Surveys to ascertain peoples experience had not been undertaken since the last inspection.

● The local authority had been supporting the service to make improvements to the quality of care but some of the new systems had not been continued when personnel had changed.

● The provider was integrated into local community networks and had working relationships with a range of professionals. Alongside the agency they ran a food bank supporting staff, people using the service and the community.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding systems were not robust.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems were either not in place or robust enough to demonstrate safe recruitment, training and support.