Andersen Care Limited

Andersen Care Agency

Inspection report

837 High Road
London
N17 8EY

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29 November 2023
04 January 2024

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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

Andersen Care Agency is a domiciliary care service providing personal care in people's own homes. At the time of our inspection there were 17 people using the service. The service was supporting older people and adults with physical disabilities.

People's experience of using this service and what we found

We found there were shortfalls with how risks which some people faced were assessed, managed and planned for. Certain high risks were not identified and fully explored. Staff did not have robust care plans to guide their practice and promote people's safety. The provider did not effectively assess this aspect of the service they provided. Improvements were required with how they assessed and managed high risks.

The providers audits did not identify the issues we found in relation to the planning and management of people's medicines, how incidents were responded to, and how staff and managers evidenced the quality checks they completed. Improvements were needed in how the provider assessed these aspects of their service.

The registered manager was open to all of this feedback and told us they would make these improvements.

Despite these findings, we found there was a positive culture at the service and people received a person-centred care experience. People's relatives said their relatives were safe and well cared for. One person's relative said "She [relative] is quite happy, their regular carer makes her laugh." Another person's relative said, "[Name of relative] is 100 per cent safe and happy. Their main carer is fantastic, [name of carer] is brilliant."

People received care visits at times they were happy with and saw a regular group of care staff. New staff were introduced to them and spent time getting to know them with a more experienced member of staff before they visited alone.

Relatives reported how respectful, polite, and caring staff were to their loved ones. One person's relative said, "They [care staff] are chatty and kind, [name of carer] dances with him, [name of another carer] shares the football news."

Staff told us they spent time with people and were not under pressure to rush about to the next care visit. If they needed to stay longer, they did and reported this to the office. The managers celebrated people's birthdays with a cake, card, and a visit from them and the person's main carer.

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.

At the time of the inspection, Andersen Care Agency did not support anyone with a learning disability or an autistic person. We assessed the care provision under Right Support, Right Care, Right Culture, as the service is registered as a specialist service for this population group. The registered manager had arranged training for themselves to assist them to make plans to fulfil 'Right Support, Right Care, Right Culture' if they supported anyone with a learning disability or autism in the future.

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 on 24 November 2017).

Why we inspected
We undertook this inspection as part of a random selection of services rated Good and Outstanding which had not been inspected for some time.

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. This is based on the findings at this inspection.

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

Enforcement and Recommendations

We have identified 2 breaches in relation to how the provider assessed the quality of the service, with risk management, medicines support.

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

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? The service was not always safe.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Andersen Care Agency

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was completed by 1 inspector and 1 Experts 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. A Pharmacy inspector also supported this inspection.

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 24 hours' notice of the inspection to enable the registered manager to arrange for us to speak with people, staff, and arrange for documents to be sent to us. The inspection activity started on 29 November 2023 and ended on 4 January 2024.

What we did before the 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 spoke with the quality assurance lead for the local authority to gain their views and the outcomes of their assessments of the service.

During the inspection
This inspection was carried out without a visit to the location's office. We used technology such as video calls to speak with the registered manager, we telephoned people, their relatives and staff. We were sent people's care records electronically in a secure way. We spoke with 2 people over the phone, we contacted more but they did not want to speak with us. We spoke with 9 people's relatives and 4 members of staff. We reviewed 3 people's risk assessments, care plans, reviews in full. Staff recruitment checks were completed for 2 members of staff. Staff rotas and spot checks, emergency plans, and quality monitoring audits were also reviewed.

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.

Assessing risk, safety monitoring and management
- We identified risks which had not been recognised, planned or monitored by the managers. This included supporting people to stay safe when making personal choices.
- Other risks for people were identified but further exploration was needed to understand and plan to manage these risks in a safe way.
- There was a lack of effective monitoring by managers which meant opportunities were missed to identify patterns, minimise incidents, and manage risk for some people, placing them at potential risk of harm.
- There was an accident and incident process in place. This was not always followed when incidents took place.

Using medicines safely
- People who were supported with their medicines did not have care plans for this, to direct staff and inform them of what they must do if something went wrong.
- Staff and managers were unclear if they were prompting or administering people's medicines.

These issues placed people at potential 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.

- We drew the issues with risk management to the registered manager's attention who ensured improvements were made to one person's risk assessment and plans.

- People's relatives felt confident their relatives were safe. A relative said, "They [staff] will call the GP if they notice anything, we work well together." Another relative told us, "They [staff] are very good at keeping on top of things and reminding me what needs to be done."

Systems and processes to safeguard people from the risk of abuse
- Staff were clear about what abuse could look like and what they must do if they had concerns. However, staff were not aware of the professionals they could also report concerns to, such as the local authority. The registered manager said they would revisit this training with staff.
- Managers had raised concerns to the local authority when they identified a concern for one person, to ensure professionals were aware of associated risks so they could assess and monitor the risk.

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). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● 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.
● Staff understood the importance of prompting choices for people. They said they were guided by what people wanted to do.

Staffing and recruitment
● People received care visits at times they were happy with. Staff were not often late, and people saw regular staff who they knew.
● Staff told us they did not feel rushed and had plenty of time to get to the next care visit.
● The registered manager had ensured appropriate and safe recruitment checks had been completed before new staff started working with people.

Preventing and controlling infection
● Checks took place to ensure staff had enough supplies of personal protective equipment PPE in people's homes.
● Staff were trained to reduce the spread of infection and people and their relatives did not report any concerns with this aspect of their care.

Learning lessons when things go wrong
● The registered manager was open to the shortfalls we found at the inspection. They took some action to correct these and told us they would learn from the feedback.

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 care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There were shortfalls with how managers assessed the quality of the service. Risks for people were not always identified and were not explored with robust care plans and guidance for staff to follow.
- An audit had identified this for one person, but no action had been taken, even though there had been some high-profile local cases recently of a similar risk. Nor did this prompt the registered manager to assess how risks were assessed, managed and monitored by their staff and managers.
- Regular audits took place, such as spot checks on staff's practice and when concerns were raised about the risks which some people faced. However, supporting evidence of this work was not documented and captured.
- The audits had not identified these issues and the shortfalls we identified in medicines management, and how incidents and accidents were managed and responded to.
- The provider failed to notify CQC when there were safeguarding investigation completed by the local authority.
- No one had come to harm as a result of these issues and the registered manager said they had listened to our feedback. But this demonstrated a lack of effective governance in this aspect of the quality of the care provided.

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

- The registered manager had created an open positive culture at the service. People received care which they were happy with, and which met their day-to-day needs. One person told us, "They're [staff] always polite, nothing seems too much for them."
- When relatives raised issues about people's quality of care, relatives said these got resolved quickly.
- Efforts had been made to promote people's well-being and a person-centred care experience for people. Staff were not under pressure to rush, and people became familiar with the staff who supported them.

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

- People had regular reviews and were asked about their experiences of their care.

● Relatives and people were asked to complete questionnaires which showed people reported positively about their experiences of care.

Working in partnership with others
● Managers worked with professionals and people's relatives to raise concerns and meet people's needs.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager talked us through their understanding of this and we were satisfied they would fulfil their duty of candour if required.

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 There were shortfalls in risk management and the monitoring of risks. Which potentially placed service users at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were shortfalls with how the provider and the registered manager assessed the quality of the care provided at Andersen Care Agency. This place service users at potential risk of harm.