

Agincare UK Limited

Agincare UK Chippenham

Inspection report

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Date of inspection visit:
07 October 2020

Date of publication:
17 November 2020

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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

Agincare UK Chippenham is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. Not everyone using Agincare UK Chippenham receives a regulated activity, CQC only inspects the service being received by people provided with 'personal care', help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

At the time of our inspection 72 people were being supported by this service.

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

Where a risk had been identified, there was not always a risk assessment in place to manage this risk and give guidance to staff. Risk assessments did not always contain sufficient detail to mitigate risks. Medicines were not always recorded safely. We saw one person had consistent gaps on the medicines recording sheet and protocols for medicines to take when required were not always in place.

Since March 2020, we have received seven whistleblowing concerns and four provider complaints about this service. When we spoke with staff they told us they did not always feel confident or comfortable in raising concerns internally and the management of these. People told us they felt safe with the staff that supported them.

We had received a number of whistleblowing concerns regarding staff not wearing personal protective equipment (PPE) appropriately. The registered manager had continued to take appropriate action when they had been made aware of these incidents. The service had implemented additional infection control measures in response to the coronavirus pandemic.

Quality assurance systems were in place to monitor the quality of service being delivered. However, these did not always identify concerns such as shortened call times, medicine errors or risk management. This meant that there were gaps in the auditing system where information was not checked, and action needed was not taken in a timely manner to keep people safe.

People were put at potential risk from not receiving the full duration of care and support they required during visits. We saw evidence that staff were not staying with people the full amount of time they had been assessed as needing and which was documented in their care plans. Staff raised concerns that missed and late visits were a regular occurrence within the service, and this was not taken seriously by the office staff.

Prior and during the inspection, staff had raised concerns with us about low morale, a negative culture and a breakdown of communication and support between them and the office and staff.

People were given the opportunity to provide feedback to the service about their experience of the care

received. The registered manager told us they had tried to engage with people more during the pandemic, so they did not become isolated. Increased phone calls and welfare checks had been made and quizzes and word searches had been sent out to people.

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 1 March 2019).

Why we inspected

The inspection was prompted in part due to seven whistleblowing concerns and four provider complaints received. These were about staff not wearing appropriate personal protective equipment (PPE), falsification of documentation, missed and shortened visits to people and a negative culture between office and management staff and care staff. A decision was made for us to inspect and examine those risks.

We undertook an unannounced focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at 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 Agincare UK Chippenham on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified two breaches of the Regulations at this inspection in relation to the management of risks, medicines and the overall governance of the service in effectively assessing the quality of care people receive. 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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Agincare UK Chippenham

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 Care Act 2014.

Inspection team

The inspection team consisted of two inspectors, who attended the site visit.

Prior to the inspection an expert by experience carried out phone calls to people using the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We spoke with 14 people and eight relatives to seek their experiences of using the service. We spoke with 10 staff members.

During the inspection

We spent time with the registered manager at the office location. We reviewed a range of records. This included six people's care plans and associated medicine records. We looked at five 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 also reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records and staffing rotas.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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; learning lessons when things go wrong; using medicines safely

- Where a risk had been identified, there was not always a risk assessment in place to manage this risk and give guidance to staff. Risk assessments did not always contain sufficient detail to mitigate risks.
- One person smoked in bed and was at risk of burns. They had already experienced an incident in July 2020 in which they sustained a burn from this. The risk assessment had not been updated to reflect this incident or to include that this person had a fireproof apron which staff needed to ensure they were wearing. We saw that this risk was also not included on the person's emergency information document so other's would not be aware or support appropriately.
- Where people had been prescribed paraffin-based creams, there were no risk assessments in place. This included one person who was known to smoke in bed (Fabric burns quicker and hotter when contaminated with emollients and can increase the risk of serious fires). There was no evidence to suggest that this had been considered or a safer alternative sought. National Institute for Health and Care Excellence (NICE) guidance states that healthcare professionals must ensure that patients and their carers understand the fire risk associated with the build-up of residue on clothing and bedding and can take action to minimise the risk.
- Staff gave mixed responses on being informed of risks to people commenting, "Everything is kept up to date, I'm well informed about changes and risks to people" and "If there are any changes then it's usually via text they send stuff out to us, any updates", "We've reported so many times that people don't have up to date care plans. If someone goes in and isn't aware of the changes, they are still following the old ways" and "They don't send you information unless you ask for it. We have an app thing where we can click on the person and it comes up with tasks, it doesn't tell us any details, it doesn't tell us if they are violent, or shy and withdrawn."
- Medicines were not always recorded safely. We saw one person had consistent gaps on the medicines recording sheet (MAR).
- The 'second check' process for handwritten MARs was not always effective. One medicine was not spelt correctly for two consecutive months and did not have the concentration of the medicine listed for four months. These mistakes had not been picked up on by the member of staff who second checked handwritten MARs.
- We saw that one person's care plan identified them as requiring no assistance with medicines, however it was clear from other documentation that medicines were being administered by staff.
- Some medicines we signed 'NR' signalling they were not required. These medicines had not been identified as 'when required' medicines and did not always have a PRN protocol in place.
- We saw some staff had signed indicating they had administered medicine that was out of stock. This

anomaly had not been picked up in the auditing process.

- We saw one member of staff had not had their competency assessed for oral medicines since 2018, when we asked the registered manager about this, they said this person only administers cream, however we saw two 'informal coaching' documents following medicines errors in 2020, relating to oral medication.
- Another staff member had a competency assessment in their file, however this was not dated and there was no record of what was observed.

There was a failure to take appropriate measures to mitigate risks and ensure people received safe care and treatment. 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

- Since March 2020 we have received seven whistleblowing concerns and four provider complaints about this service.
- When we spoke with staff, they told us they did not always feel confident or comfortable in raising concerns internally and the management of these. Staff said, "You can't call the office and report someone, you should be safe knowing they won't tell that staff member, but they do. Confidentiality and privacy only comes into effect when it suits them", "I am aware that several clients and several carers have contacted CQC. People have told me that they've done it" and "Staff have had enough going to office so they are trying to go higher and external as they are desperate and not listened to." This meant people may be at risk of harm from staff not trusting in the organisational systems to manage safeguarding concerns and be taken seriously.
- We have fed these concerns back to the management team to consider their internal processes and building trust so staff feel encouraged to raise concerns internally.
- Staff had undertaken safeguarding training and were aware of their responsibilities to identify and report potential abuse. Staff told us, "Whistleblowing policy is in place, yeah I am knowledgeable about whistleblowing. I would feel confident", and "Yes, I would do this, it's not a nice things to do but your main concern is the people you look after, they are vulnerable and you have to be their voice."
- People told us they felt safe and trusted the staff that came into their homes commenting, "I have never had anything taken. I have got my purse lying there and they never touch anything. They always ask me if there is anything else I want doing", "100 percent, absolutely safe" and "I do [trust staff]. I just trust them. They are polite and professional."

Staffing and recruitment

- The service had experienced some staff turnover and were at the time of the inspection understaffed. The registered manager told us they were actively recruiting and had some interviews lined up. Visits were covered by current staff picking up extra hours or office staff. The registered manager had also been out on some visits.
- People told us they were happy with the staff that visited them and that they mostly had regular staff visit commenting, "They are friendly and sociable. The lady I have got now is very nice" and "I get the same staff."
- Staff did not always speak positively about staffing, the way visits were scheduled, and the changes communicated about their rotas. Staff told us, "Rota's are rubbish, really inconsistent, we haven't got a clue who we are going to and there's no fluency", "The staff turnover is high, we have a standing joke that we won't learn their name until they have passed their probation as they will leave" and "We get a lot of new staff coming in and you see the people they hire and we know they aren't going to stay. They give our calls away to them and then they call in sick and we have to pick the hours again, they aren't loyal to us."
- The registered manager told us they were aware of the issues staff felt and that a new rota co-ordinator had been in place for six months and that there had been an improvement now in the rotas.

- Safe recruitment checks had been completed for the majority of new employees. These included references from previous employees and a check with the Disclosures and Barring service (DBS) to ensure staff were safe to work with vulnerable adults.
- We saw that one person had a DBS in place, however had no overseas police check. This person had been living overseas up until their employment began. This meant the employer had no assurance of this person's good character before beginning work with vulnerable adults. The registered manager told us they would look into this.

Preventing and controlling infection

- There was limited assurances that staff were consistently wearing the correct PPE to limit the risks of infection and cross-contamination. We had received a number of whistleblowing concerns regarding staff not wearing personal protective equipment (PPE) appropriately. The registered manager was in the process of investigating an incident prior to our inspection where a staff had not worn the correct levels of PPE during a visit putting the person and themselves at risk. The registered manager had and was continuing to take appropriate action when they had been made aware of these incidents.
- Staff were mixed in their responses about PPE being worn commenting, "This is a thing with Agincare staff not wearing PPE but I know before the pandemic when I did double care calls they didn't wear the correct PPE for personal care. I did report it, they said no one wears it, they saw other staff not doing it and they continued this", "I have seen staff not wearing PPE, they say they forgotten or it's too hot. Some don't put it on until in the house but should be doing it before entering the house" and "I always do, mask, aprons and gloves. We wear it all the time. No every time I'm with someone they are wearing it all" and "I have felt safe, they provide all the PPE. Not seen staff not wearing it."
- People we spoke with told us staff wore the correct PPE during their visits saying, "They do wear all the right stuff" and "Yes, they are all very careful."
- The service had implemented a number of additional infection control measures in response to the coronavirus pandemic. This included additional PPE, regular cleaning of the office and virtual or socially distanced meetings.
- Staff had received training in infection control. The registered manager ensured regular communications were in place to update care staff about changes in infection control guidance.
- Spot checks and feedback questionnaires included checks on infection control practices.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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

- Quality assurance systems were in place to monitor the quality of service being delivered. However, these did not always identify concerns such as shortened call times, medicine errors or risk management. This meant that there were gaps in the auditing system where information was not checked, and action needed was not taken in a timely manner to keep people safe.
- We reviewed some medicine audits and saw that in August 2020, 16 staff had been identified as leaving gaps on medicine records. We saw that action had been taken to hold informal coaching with staff, however the gaps on MAR's had continued. There had been no considerations to looking at the overall approach to medicines to assess why these errors continued, such as if the training was sufficient or if staff were rushed during visits and did not have time to complete paperwork.
- We identified that one notification of abuse had not been submitted to the Care Quality Commission in June 2019 under the previous registered manager. The current registered manager informed us that this notification would be submitted as an historical event based on the information they had available. This had not been identified through the provider's audit systems.
- The provider had failed to ensure they had effective governance systems in place in order to identify and take timely action in response to shortened visit times that staff were recording.
- Staff raised concerns that missed visits were a regular occurrence within the service. We were made aware of two missed visits prior to our inspection. The registered manager investigated and reported that this was due to a staff member being late, so people chose to cancel their visits.
- Staff commented, "There has been times people haven't received their visit, seen this happen quite a lot of times. The [registered] manager says she puts a safeguarding in when there is a missed visit and I have to trust that she does" "They [people] just tell me on a Monday or Tuesday that they were supposed to have a visit on Sunday, but they didn't come" and "I have been aware of people not receiving their visits, it happened last weekend. The office is renowned to sneak calls on you without letting you know. There are a few people missing their calls and they end up cancelling but its missed."
- One staff member spoke of not taking allegations of missed calls seriously saying, "I just change the subject and say I'm here now. I don't want the clients to get worked up about it so I just get on with it really. You just don't know whether that was true or not, you don't know if they've got dementia". The staff member said they always check with the office, however this further reflected a concerning culture in taking people's concerns seriously.
- People were put at potential risk from not receiving the full duration of care and support they required

during visits. We saw evidence that staff were not staying with people the full amount of time that they had been assessed as needing and documented in their care plans. We reviewed six people's care notes and found evidence that five people had multiple incidents where their full call had not been completed. For example, one person who required a 60 minute morning visit had only received a care visit lasting just 20 minutes. This meant this person had been left at risk of not receiving appropriate care.

- The registered manager told us 10 percent of these records were audited a month, so it was not known how many people were not receiving their full allocated visit time. We saw that where an audit had taken place, it had not identified all of these concerns. The registered manager confirmed that cutting people's visits short had not been notified to the Local Authority. Following this inspection, we have raised our concerns with the commissioning and contracts team who will be reviewing this to ensure people are not at risk of unsafe care.
- Staff told us they were not given enough time to travel between people's houses and it was an organisational failing. We reviewed the staffing rotas and saw staff often finished a visit at the same time another was due to start. This meant one visit would always be finished early or be late and no travel time had been factored in-between.
- Staff said they had to choose between leaving early or being late to their next person commenting, "Staff are writing times down and not the correct times, they aren't staying the full time on visits. The office don't seem to care when they check this", "[office staff] reallocate people, they've gone somewhere else, that job has been left open and they have forgotten to reallocate somebody", "[staff member] said she'd cover a call, but they never got back to her to confirm the call, so that person didn't get their call." We raised the concern about incorrect times being recorded with the management team, who investigated and did not substantiate the allegation.
- People had mixed experiences of visit times. Some people spoke positively saying, "No missed calls. [Regarding late calls] I am not worried about it, if it's not too frequent", "Always on time" and "They [carers] always stay the full hour, I insist on that." Other people told us, "This morning they phoned to say the carer would be here about 11am. She's supposed to stay about 2 hours. Sometimes they don't", "They might be due here at 9am, but on their rota they are leaving their last service user at 9 a.m. so I do feel sometimes the office expects a lot of the carers" and "The medication timetable needs to be adhered to. Afternoon is okay, but morning is still bad time keeping. I have spoken to the office, they make all sorts of excuses."
- Whilst it is appreciated that there is an ongoing pandemic, there was no evidence of risk assessments, conversations with commissioners or documented evidence as to why visits were not being fulfilled according to the assessed need in people's care plans. The service had also not needed to implement their contingency or crisis management plan during this time to manage any staffing shortages or local responses to the pandemic.

The failure to operate effective systems and processes in order to identify risks and take timely action 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

- Prior and during the inspection staff had raised concerns with us about low morale, a negative culture and a breakdown of communication and support between them and the office and staff.
- The majority of staff we spoke with commented, about feeling unhappy and not having positive relationship with the office staff commenting, "We are not happy with the office at the moment", "Things are not kept private, personal things become known, staff were told and I had service users asking me questions about my personal life which is not right", "They [Office staff] say we are complaining about nothing, making mountains out of molehills. Really, she [registered manager] should be made alert that she's got unhappy

staff" and "They [Office staff] are not really someone you can count on, they will listen to you and promise you things but when it comes down to actions they don't, they lie, they say they didn't know. I raise things to all the office staff and nothing happens."

- Other members of staff told us they did feel supported, commenting, "The manager at the moment, she will offer a drink, something to eat, she always comes out and has a chat with us" and "The people in the office and the manager are very supportive. I think it's very important."
- We spent time discussing this with the registered manager who was keen to address how staff were feeling and find ways to reconnect with them. The registered manager explained it had been harder during the pandemic and not being as visible to staff and they had tried to find ways around this. The registered manager had created a welcoming and private space in the office to encourage staff to be comfortable if they wanted to come in and talk.
- People and their relatives gave mixed feedback on the communication they received from the office. Some were positive and commented, "The manager was extremely pleasant, and I found her very approachable and they were able to take on the care very quickly", "She's [registered manager] always there or one of the staff is always available. We are on first name terms" and "They have a very pleasant manner, everything has a pleasant, friendly feel."
- Other people and relatives however told us communication was not good saying, "The right hand doesn't know what the left hand is doing. Communication is not accurate. They don't pick up the phone to ask if it's OK to come at a different time" and "I am looking around for another firm. They are very friendly, but [it's because of] this lack of communication between them and the carers and the timings." During our site visit we observed a member of the office staff speaking to a service user on the telephone. Although the registered manager explained this person rings a lot, the manner and tone in which they were spoken too was not respectful. The registered manager said she would address this with the office staff.
- We saw there had been some examples where communication had not effectively reached staff. For example, when one person had sadly passed away staff had continued to turn up to the relative's house to provide care on two further occasions which was distressing for all involved. Another staff member had gone to undertake a visit but had not been notified that the person had gone into hospital. We spoke with the provider about the need to review how they send out information to their staff to reduce events like this going forward.

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 understood their responsibilities in responding to concerns raised. The registered manager told us an acknowledgement letter was sent prior to investigating and with the final response a further meeting offered. One person told us, "We don't get any real problems. I feel satisfied with the outcome, they have always sorted it straightaway."

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

- People were given the opportunity to provide feedback to the service about their experience of the care received. We reviewed the recent feedback collected and saw positive responses recorded. One person told us, "I have had a survey recently, but they do spot checks and sometimes I am asked my opinion about the carer."
- The registered manager had constructed a board at the office in which compliments were put up so staff visiting could see these.
- Staff had also been given surveys to complete, however only five staff had chosen to give feedback in this way.
- The registered manager told us they had tried to engage with people more during the pandemic so they

did not become isolated. Increased phone calls and welfare checks had been made and quizzes and word searches had been sent out to people.

Working in partnership with others

- The registered manager told us they had received good support from external professionals during the height of the pandemic, and had continued to liaise with occupational therapists and community nurses where 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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Where a risk had been identified, there was not always a risk assessment in place to manage this risk and give guidance to staff. Risk assessments did not always contain sufficient detail to mitigate risks.</p> <p>Medicines were not always recorded safely. This was observed in gaps on medicine records, signing for out of stock medicines and a lack of protocols for medicines to be taken when required.</p> <p>Regulation 12 (1) (2) (a) (f).</p>
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Quality assurance systems were in place to monitor the quality of service being delivered however these did not always identify concerns such as shortened call times, medicine errors or risk management. This meant that there were gaps in the auditing system where information was not checked and action needed was not taken in a timely manner to keep people safe.</p> <p>Regulation 17 (1) (2) (a) (b) (f).</p>