H&M Care Agency Ltd

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Inspection report

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Date of inspection visit:
30 April 2019

Date of publication:
21 June 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, some living with the experience of dementia, people with learning disabilities and people with mental health needs. The majority of people had paid privately for their care. At the time of our inspection four people were using the service.

People's experience of using this service and our findings:

Relatives told us they were happy with the care that was provided by H&M Care Agency.

Safe recruitment practices were not always followed when recruiting staff.

The service was not always working within the principles of the Mental Capacity Act 2005 which meant that people were not always supported to have their personal views taken into account when decisions about their care was being made.

Support plans did not always provide sufficient details about people's background therefore staff may not have sufficient information to provide safe care and support.

The provider did not have effective quality assurance systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people.

Staff understood the provider's safeguarding policies and were familiar with the reporting procedures.

Staff had access to appropriate personal protective equipment (PPE) to help prevent the spread of infection.

Staff had access to training which was appropriate to their role. This included safeguarding, health and safety and moving and handling.

The provider had systems for handling complaints and responding to incidents and accidents which they said they would follow when complaints are made or incidents occur.

Relatives told us that people were treated with dignity and respect. They were also positive about the staff and they told us that staff had a caring attitude.

Rating at last inspection: This is the first inspection of the service.

Why we inspected: This was a planned inspection that was part of our inspection schedule.

Action we told the provider to take: During the inspection we found five breaches of regulations. These were

in relation to safe care and treatment, fit and proper staff employed, consent to care, person centred care and good governance. You can see what action we told the provider to take at the back of the full version of the report.

Follow up: We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

For more details please see the full report which is on the CQC website at www.cqc.org.uk

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 effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

H & M Care Agency Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by two inspectors.

Service and service type: H&M Care Agency Ltd is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides services for people who have dementia, mental Health, older People, people with an eating disorder, physical disability sensory impairment and younger adults.

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:
We gave the service three working days' notice of the inspection visit because we needed to be sure that the manager would be available.

We visited the office location on 30 April 2019 to see the registered manager and office staff and to review care records and policies and procedures.

What we did:
Before the inspection we looked at information we held about the service including registrations assessments reports. The provider sent us their Provider information Return. This is information that we require providers to send to us annually to give us some information about the services, what the service does well and improvements they plan to make. We also requested feedback from the local authority.

During the inspection we spoke with the registered manager and the nominated person and two members of staff. We looked at three people's care plans, staff training files, policies for safeguarding, complaints and incidents, team meetings minutes, staff memos, and recruitment files for two staff.
We requested one fluid intake and monitoring form for one person. This was sent to us after the inspection.

After the inspection we spoke with three relatives of people who used the service and one member of staff.

For more details please see the full report which is on the CQC website at www.cqc.org.uk

Requires Improvement

Is the service safe?

Our findings

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

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. Regulations may or may not have been met.

Staffing levels

● The provider did not always follow safe recruitment procedures before employing staff. Staff did not always have a full employment history, together with a satisfactory written explanation of any gaps in employment. In one staff member's recruitment file there was evidence of employment history for only two weeks. The provider explained that this person had only recently arrived in the United Kingdom and indicated they were not aware of the legal requirements to have a full employment history.

● We looked at another staff member's application form which stated they had one year's experience of care work. However, when we read this person's interview notes they stated, 'I worked as a care worker for many years where I was helping elderly clients in their day to day needs.' This disparity had not been explored by the provider which meant we could not be confident that the provider had robust arrangements to make sure staff were suitable to care safely for people using the service.

The above demonstrates a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In staff files we saw evidence that the registered manager had completed Disclosure Barring Service (DBS) to check to see whether there was evidence of applicants having criminal convictions or not, or whether they were on any list that barred them from working with people who needed care.

Assessing risk, safety monitoring and management; Using medicines safely

● Another person's risk assessment stated that "Person needs prompting to take medication". The provider told us they did not currently administer medicines for people but there was no information in the risk assessment about what 'prompting' entailed. The National Institute for Health and Care Excellence (NICE) guidance on the management of medicines for people receiving social care in the community advocates providing detailed and specific directions for what the care worker is required to do to support the person with their medicines.

● The provider completed risk assessments to identify the risks people faced while receiving a service. We noted that risks had been appropriately identified but the risk management plans were not always robust enough to clearly inform staff of the action they needed to take to minimise the risks. For example, one person's risk assessment read "Encourage to mobilise more" however there was no information on how staff were meant to provide this support.

The above demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Training records indicated that staff were trained to administer medicines and staff told us they felt capable to do so. Within the staff training matrix we saw evidence of competencies check been completed.

Systems and processes to safeguard people from the risk of abuse

● Relatives told us their family members felt safe using the service. One relative said, "My Dad feels very safe" and another relative said, "We know them well."

● Each person's care plan had a section which was called 'Preventing and reporting abuse' and they documented local authority safeguarding contact details.

● There was an up to date safeguarding policy. Staff were trained in this area and knew how to report any safeguarding issues.

● The registered manager had not raised any safeguarding alerts since they started to operate the service however, the registered manager and the nominated individual were aware of their responsibility to inform the local authority and the Care Quality Commission (CQC) of any safeguarding concerns.

● There were appropriate staffing levels in place at the time of inspection. We saw evidence of this in the staff rotas. Staff told us they had enough time to travel to appointments.

Preventing and controlling infection

● There was a policy on infection control which included guidance about good practice for hand washing and stated staff should wear protective clothing when supporting people with personal care. The registered manager told us they took supplies of gloves and aprons to people's homes and staff also confirmed this. One relative told us, "They always wear gloves and aprons."

● Staff confirmed they did this. "I did training and they told us that we must wear gloves, each task requires new gloves and hand wash. Infection control is about prevention of infection."

Learning lessons when things go wrong

● The business is only open a year and to date there had been no incidents, accidents, concerns or complaints. The provider has policies to deal with issues as they arise, they told us "We call monitor and check our work".

●One staff member told us that accident forms are kept in people's houses "I have to complete it and the manager will access it. I must record everything that happens".

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

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA, and we found they were not.

● The provider was not following their own policies and procedures relating to the MCA. Information around people's capacity to consent was not clear and sometimes contradictory. For example, under medicines for one person we saw recorded the person had capacity, but they also had a best interests' decision that had been made on their behalf. Furthermore, there was not a mental capacity assessment. This contradiction meant the information recorded by the provider did not identify what aspects of the person's care they could consent to and did not provide clear guidance for staff.
● We read in one person's file under Medication 'Consent to administer', 'I do not require any assistance with my medication. This person was defined by the MCA to have capacity to sign however, a family relative had signed this form on the person's behalf.
● We found that the provider sought consent to people's care by asking relatives to sign care plans. The provider explained, "We spoke to the daughter as [person] is unable to sign". We asked if the person had capacity and the registered manager told us they did. We saw evidence in three people's care files that relatives had signed care plans on behalf of the people using the service but there were no records to show that they had the legal authority to consent to care on behalf of the people using the service.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People had food and fluids monitoring charts. One person's care plan stated that the person needed encouragement to drink more fluids. We asked the staff member how they supported the person to drink more fluids and they explained, "I make them tea." However, this person's 'diet and drinks monitoring' form was not always completed therefore staff were not always recording information consistently.
● People's relatives said that staff assisted in food preparation, where this was part of the care plans. A relative told us, "[Staff] warms the food that my mum prepares for my Dad."
● We saw evidence of food preference forms which was broken down into breakfast, lunch, dinner and snacks. There was information to record, dietary requirements, allergies, likes but not dislikes. We

highlighted this to the registered manager and they informed us they would amend the forms.

Staff working with other agencies to provide consistent, effective, timely care
● We found evidence of the registered manager interacting positively with a social work team from the local authority. Where necessary staff advocated on behalf of people to ensure they received the support and healthcare they needed. For example, the service was able to advocate on behalf of a person to obtain a hospital bed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider completed assessments of people's needs when they were referred to the service to make sure the provider's staff would be able to meet the needs of the people referred to them. Care plans were developed within 24 hours of a person being referred. Assessments contained information on the person's personal care, nutrition and hydration, medical and health requirements.

Staff support: induction, training, skills and experience
● Staff told us that they received a good induction. One staff member said, "My induction was good and useful." The induction incorporated the training that the provider considered mandatory and shadowing with the nominated individual. There was an induction record on staff member's files which documented the induction process.
● Staff had formal supervision every three months and they told us they felt supported. We saw evidence of supervision notes in staff files.
●At the time of the inspection no staff had an appraisal as they were not in post for a year. However, the provider told us that staff will receive an appraisal in line with the policy.

Supporting people to live healthier lives, access healthcare services and support
● At the time of our inspection the provider told us they had not had any interaction with any health care services as people using the service lived with relatives. However, staff told us that they would be happy to contact health care professionals.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires improvement: People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
● Relatives told us that staff were caring. One relative said, "[Staff] is very good and kind, they are so nice and friendly. They feel like one of [person's] children because they are so kind."
● Staff told us they respected people. One staff member said, "I always treat people like my family or my mother. I show compassion and understanding."
● Where people had equality and diversity needs, they were recorded in care plans. Relatives told us that people's individual preferences and needs were being met.
●Care plans recorded people's preferences as to whether people preferred to receive support from male or female staff. Relatives told us that care workers were suitably matched with people. One relative told us, "We wanted a male carer and someone that spoke [person's] language and the carer understood [person's] needs". This helped to ensure that people were treated and supported well by staff.
●Notwithstanding that staff were individually caring, the provider had not ensured that people were always supported in a caring way. At this inspection we identified many areas that needed to improve to make sure people received safe and appropriate care. The provider has however not acted in a caring way to identify and address all these issues, so people received care safely and were protected from risks that can arise if fundamentals standards of care are not met or good practice guidance are not followed. For example, the provider had not sufficiently improved the way risks were managed, staff were recruited or consent to care sought from people.

Supporting people to express their views and be involved in making decisions about their care
● Staff recognised that people's caring needs changed on some visits. One staff member told us, "Some days people don't want to talk, or they might prefer to sit outside for their lunch". This helped to ensure that people were able to be involved in making decisions about their care.
● Relatives told us that care workers fitted in with people's schedule, "I help the carer with the personal care and sometimes I am running late, if I call they return my call and the carer will work around my day."
● The provider had an awareness of the Accessible Information Standard (AIS). One staff member told us how a person was supported with communication cards to help them.

Respecting and promoting people's privacy, dignity and independence
● Relatives told us that people's dignity and privacy was respected. One relative said, "[Staff] respects dignity and privacy every time."
● Relatives told us that staff encouraged their family members to be independent. One person told us "They are doing an excellent job. [Person's] mobility has improved since they started providing care."
●Staff received Privacy and Dignity training. One staff member told us "Respecting dignity and care is so

important in care, I close the door and I ensure that I respect their dignity".

Requires Improvement

Is the service responsive?

Our findings

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires improvement: People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● Care plans did not contain information on people's social, family, likes or hobbies. This meant what was important to people was not recorded by the service and therefore could not be known if there was a change of staff.
● Care plans covered areas such as personal care, nutrition and hydration, medical and health requirements. However, they were not always personalised. For example, care plans were all completed in written English which not everyone could read. Care plans did not have photos, details of people's individual preferences. We read in one person's file that they needed assistance with showering, however there was no information on what assistance was required therefore carers did not have the information to provide the appropriate care to meet people's needs and wishes.
● We saw evidence that review meetings had been held but these did not indicate people had been involved in their reviews. This meant people were not always involved in making decisions about their care.
● We asked relatives if carers understood people's needs and we were told that they did. One relative said, "[Person] is allergic to some things and the carer knows and she knows person's ways." However, this was not recorded in the care plan which meant that new staff would not know this information.
● Daily notes recorded the care provided for people by staff and were reviewed by the registered manager at the end of each month. However, the notes were task focused rather than person centred. For example, one person's care file stated, 'Carers should always reassure person and assist with mobility when going to the shower.' We saw no evidence recorded that the person was reassured.

This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● At the time of the inspection the provider had not received any complaints. They had a complaints policy and systems to deal with complaints. Relatives told us that they were aware of the complaint's procedure. One relative said, "We have a book and it tells us what we can do, there is a complaint form in the book". This told us that relatives understood the process to make complaints.

End of life care and support
● We found end of life care plans were not always detailed. The registered manager told us there were cultural reasons for this. They said, "Culturally some people do not want to discuss end of life". This reflected what we read in one person's file as they did not wish to discuss end of life due to their religious beliefs.
●The provider told us if people wanted to discuss end of life wishes, staff were able to provide the required

support as they had received the relevant training.

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.

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

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

- The provider did not have effective quality assurance systems to monitor service delivery as they had not identified the issues and concerns we found at the inspection, so they could take action to make the necessary improvements. For example, the provider's checks on staff recruitment were not robust to identify concerns we found around the employment references and the employment histories of applicants so that these could be put right.
- Care plans were not audited to check that they contained all relevant information such as people's preferences and addressed all of people's needs in a person centred way. Risk assessments were also not always robust enough to mitigate identified risks. In addition, the provider's quality assurance arrangements was not effective because they had failed to identify that the provider was not always following the principles of the MCA and decisions about people's care was made by family members without evidence that people lacked the mental capacity to make decisions or that the family members had the legal authority to make decisions on behalf of those receiving care.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was aware of their responsibilities in ensuring that CQC were notified of significant events if they occurred within the service.
- Records were securely stored within a locked office.

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

- There were monthly office and management staff meetings taking place, however there was no staff meeting for all care workers to attend. Staff told us that staff meetings do not happen as it is difficult to get all staff together. The provider explained that they send memos to staff. The provider told us that when the team gets bigger they would have team meetings.
- The provider completed satisfaction surveys to ensure the care was appropriate for people. We read some of the completed questionnaire and relatives were completely satisfied.
- Relatives told us that they were asked if they were satisfied with the care their family member received. One relative told us, "I regularly receive phone calls asking if everything is good". We saw evidence of telephone monitoring being completed by the registered manager.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● People and their relatives told us the registered manager was approachable and sensitive to people's needs.

● There were clear management structures in place. Staff were clear on their roles and where to seek support from. Staff told us they felt supported in their roles and felt listened to by the registered manager. Staff told us that they felt supported by the manager, "I am happy because I feel supported".

●Staff said they felt able to report any concerns or poor practice as they were told the importance of reporting issues. One staff member told us if they had concerns they could contact the local authority.

Continuous learning and improving care

● The provider conducts quality assurance questionnaires every quarter. The document explained it was a process for gathering information and improving care. All of the questionnaires were positive. The provider told us that they use this questionnaire to identify any potential concerns.

● The provider told us that the service is always learning. The registered manager told us "We are committed to improving our service". The provider is planning to use an electronic call logging system in the future as it will help improve care and monitor staff compliance.

●The registered manager had attended some forums within the local authority area and was keeping up to date on issues relating to social care using the CQC website which helped improve practice.

Working in partnership with others

● The service is still in its first year and the provider is establishing professional relationships with health and social care providers within the local area. To date the provider has contacted some local domiciliary care agencies.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure that care was designed for people with a view to achieving service users' preferences and ensuring their needs were met. The registered manager did not always demonstrate that they fully involved people in making decisions about their care and treatment. Regulation 9 (1) (3)(a)(b)(d)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager did not ensure that care was always provided with the consent of the relevant person and that procedures for obtaining consent to care and treatment reflected current legislation and guidance. Regulation 11(1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not always done all that was reasonably practicable to mitigate the risks to the safety of service users.

	The provider did not always ensure the proper and safe management of medicines. Regulation 12(1)(2) (a)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person was not always operating effective systems and processes to assess, monitor and improve the quality and safety of the service. Regulation 17 (1) (2)(a)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not make sure that recruitment procedures were operated effectively to ensure the information specified in Schedule 3 was obtained in relation to each person employed. Regulation 19(1)(3) (a) Schedule 3