AC Care Services Limited

AC Homecare

Inspection report

Pure Offices
26 Bridge Road East
Welwyn Garden City
Hertfordshire
AL7 1HL

Tel: 01707696474

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13 August 2018
20 August 2018
22 August 2018
13 September 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

AC Homecare is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and specialist housing. It provides a service to adults and older people, including people living with dementia who live in their own homes. There were fifty three people using the service. At the time of the inspection the office location on our register was Pure Offices, 26 Bridge Street East, Welwyn Garden City, AL7 1HL however the service was operating from1st Floor Venture House,5 & 6 Silver Court,Welwyn Garden City,AL7 1LT. The provider had submitted an application.

AC Homecare has been without a registered manager since January 2018. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We undertook an announced inspection of AC Homecare initially on 14 August 2018 in response to whistleblowing and concerns raised about the lack of robust staff recruitment, staff training and the behaviour of the manager, who had been in place since January 2018.

We found that nine of the staff employed since January 2018 had not received any training nor correct pre-employment checks or DBS before supporting people in the community. These nine staff had to be removed immediately from working until all checks and training had been completed.

We found the manager had been dismissed from the agency on 10 August 2018.The manager had replaced the original care plans with an electronic system of care plans for staff to access. However not all information had been transferred and assessments of risks to people were not completed. People said they did not have access to care staff's daily notes and health professionals could not access peoples medicine records.

At our last inspection on 26 May 2017 the service was rated requires improvement as further developments were needed in the assessments of activities or areas that could pose a risk to people as there was insufficient information to inform staff how to manage situations. At this inspection we found there was still insufficient information to inform staff how to manage potential risks to help maintain people's safety.

There was a lack of systems for the provider to assess the quality and effectiveness of the management and of the service. The systems in place were reliant on the manager to complete. Systems in place for the provider to assess the quality and effectiveness of the service were ineffective as they had not identified the concerns ..

The provider responded to our findings in an open and transparent way and was committed to remedy the situation and began a significant amount of work to achieve this. The provider took on the management

role of the agency together with the care supervisors to ensure that people received care and were safe. They informed Hertfordshire County Council who supported the agency by arranging the care of ten people to ensure their care needs were met.

Since the first day of the inspection the provider and care supervisors staff worked on completing assessments of areas of risks for people. They ensured each person had a folder with their care plan and information about the agency and put in place a medicine booklet to record current medicines and any allergies.

Whilst staff were suspended from active working and awaiting full employment and DBS checks they undertook training and once they received DBS and their other employment checks, they shadowed staff and before working alone were signed off as competent in their level of training .

People and their relatives said they felt safe with the care staff and that their privacy, dignity, and independence was respected and promoted.

People told us staff always asked for their consent when providing care and always encouraged and involved them.

People and their relatives had confidence in the way the provider managed a difficult time and said they had been informed of the situation and were sure the service would work through and resolve the situation.

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 safe

Risks to people's health and well-being had been not been identified, assessed and managed appropriately.

There was not a safe recruitment practise in place. Staff had been employed without robust recruitment, checks or training.

Medicines were not always managed safely as training was not in place for new staff.

Staff understood about protecting people from abuse and understood how to escalate any concerns.

Is the service effective?

Requires Improvement

The service was not effective.

People were supported by some staff who were not trained or supervised.

People's consent was sought before care was offered.

People were supported to eat and drink where needed.

People were supported to access health care professionals as necessary.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect.

People's dignity and privacy was promoted.

Is the service responsive?

Requires Improvement

The service was not responsive.

People, and their relatives if appropriate, were involved in planning their care.

Care plans were not always personalised nor reflected people's individual needs and requirements.

People were aware of how to raise any concerns or complaints. The system to manage complaints was not always applied.

Is the service well-led?

Requires Improvement 

The service is not well led.

The provider did not have oversight of the service or of the management team.

There was no registered manager

There were not effective quality assurance procedures. There were no regular audits completed to monitor the quality of the service, identify risks and take action.

People were confident in how the provider and senior staff were open and managing the situation and felt listened to and their concerns acted upon.

AC Homecare

Detailed findings

Background to this inspection

This inspection took place on 14,20,22 August and 13 September 2018 and was announced. We provided 48 hours' notice of the inspection because the location provides a domiciliary care service and we needed to be sure staff would be available for us to talk to, and that records would be accessible. The inspection was undertaken by two inspectors.

We did not ask the provider to complete a Provider Information Return (PIR) as part of this inspection process. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

The inspection was prompted by a whistleblowing and concerns raised in relation to the lack of robust staff recruitment and staff training and the behaviour of the manager, who had been in place since January 2018.

During the inspection we spoke with the provider, seven staff, of these three were seniors. We looked at the care records for six people who used the service to see if they were reflective of their current needs. We reviewed all 24 staff recruitment files and training records. We also looked at further records relating to the management of the service. On the 20 and 22 August 2018 we telephoned twelve people and spoke with seven people who use the service and three relatives about the service they received.

Requires Improvement

Is the service safe?

Our findings

Concerns raised stated staff recruited since January 2018 had not been through a robust recruitment process with the required checks. Once the provider had been alerted of the concerns and whistleblowing he worked to identify staff who had no Disclosure and Barring Service (DBS) and had not been recruited safely.

We looked at all 24 staff files and found nine staff who had no DBS and were also missing either a second reference, had unexplained gaps in employment and or no second proof of identity. None of the references in place had been verified to show they were genuine. Some application forms were partially filled in and the previous manger's staff file was missing. The lack of thorough recruitment procedures meant there was a risk staff were not fit and appropriate to work with people using the service. The nine staff identified were removed from duty immediately until all checks been completed to ensure staff were suitable to be employed. Returning to the service on the 13 September we found staff had completed their recruitment checks and seven of the nine staff had received their DBS and were able to begin work again.

Systems to check whether staff were safe to work at the service, were not used and staff were employed without any robust recruitment process. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection on 26 May 2017 we found further developments were needed in the assessments of activities or areas that could pose a risk to people as they were not always detailed or contained sufficient information to inform staff how to manage situations.

At this inspection we found that some of the risk assessments carried out had not been transferred to the new care plans and so were not accessible to staff. The new risk assessments completed were generic and lacked any individual detail as to how to support people whilst minimising risk. For example, an assessment for supporting someone to transfer from a bed and from a wheelchair stated "care practitioners to all ensure they are following safe manual handling procedures to minimise injury to themselves and client". However, details to inform care staff how to support that person were not given which put the person at risk of not having support in the correct and safe way in line with their individual needs. The provider acted immediately to amend the risk assessments and lessons learnt from were discussed with staff.

We spoke with seven staff during the inspection. Two of the staff were not confident in supporting people when they required support in being transferred from a bed to a chair and did not have moving and handling training. One care staff said, "I didn't have the training, I just had the information on the telephone app which is where we see people's care plans".

One person we contacted told us "Normally the staff had information about how to support people but under the recent manager new staff members turned up with no knowledge of the person they were to support".

Returning to the agency on the13 September 2018 we found the provider had booked all staff on moving and handling training and a new care supervisor was carrying out all new risk assessments on people whose activities within their care might pose a risk to them and care staff.

Some people were assisted or prompted with their medicines. Most of the people spoken with were happy with how care staff supported them with their medicines. One person said, "Yes they do help with medicines, never any problem, always on time." However, some staff spoke of how they started work without any training in supporting people with medicines. One staff said, "I felt quite upset, I had no training in helping people with their medicines".

We received a concern about when the paramedics had arrived to assist someone they had no access to the medicines the person had taken as all the information was held electronically. This meant they were unsure how safe any medication they wished to give the person would be. The lack of a transparent and open system for recording medicines is unsafe as healthcare professionals require access especially in emergencies.

The provider has since produced a medicine booklet to be retained in each person's home for ready and open access to relevant healthcare staff.

There was a repeated lack of detailed assessments of activities or tasks that could pose a risk to people and a lack of a safe system of providing and recording medicines these are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that sufficient numbers of staff were planned to keep people safe and meet their needs, although the lack of travel time did sometimes impact the timeliness of visits. However, the majority of people said staff were on time. The provider had reviewed staff rotas and ensured travel times were included.

The service did not always manage the control and prevention of infection. New staff had not received training and one staff had not been supplied with appropriate Personal Protective Equipment (PPE) such as disposable gloves. However, the provider acted immediately to remedy the situation.

All staff spoken with knew about safeguarding people from harm and explained how to identify and report any concerns relating to the risk of abuse. All staff knew, and had no hesitation, in reporting any concerns. One staff member said, "If I had any concerns about a person I would speak to the office or on call staff, we have to keep people safe they trust us".

Requires Improvement

Is the service effective?

Our findings

People were not always supported by staff who were trained and supervised. Concerns raised were that some staff had received no training and that there were also falsified training records.

We saw training records where staff were supposed to have carried out six training sessions in a day. The provider had found out, whilst looking for information requested by CQC following the concerns, that some staff training records had been falsified by the manager who had since been dismissed. The provider immediately began to act to obtain training for staff effected and put in place a competency check post training.

We found newly recruited staff had received no training and on occasions had started work with no introductions or handovers to people they were about to support. One staff member said" The first morning I started at the agency I was with another staff member then at lunchtime they said now you are on your own I couldn't believe it. I had been told I would receive a week's shadowing".

Staff employed before January 2018 had not received any training updates since January apart from medicine training. Staff said they had received no supervision from the dismissed manager and they had not felt supported by them due to their aggressive manner. One staff member said, "I did have a spot check recently from the manager but they just came and told me to sign the spot check without talking with me or doing anything".

The lack of appropriate support, training and supervision meant staff may not have had the skills necessary to support carry out their role in supporting people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider acted quickly in response to the failings in staff training and supervision. He contacted a local provider and enrolled staff on the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. He also booked staff on moving and handling training, and social care on line training. One new staff member who, since the start of the inspection, had completed a week's Care Certificate course said "Now I know what I am doing. I have also been shadowing experienced staff and the provider has been really encouraging and explained what went wrong and how it will all be from now on".

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 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 particular 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 found that they were.

People told us staff always asked their permission before supporting them with any task. One person said,

"They do always communicate with me and encourage me in many ways, they make me feel like they care." People's relatives told us that staff always asked permission from people before they carried out any task or personal care and involved them as much as possible even if the person's ability to hear them or to understand them was limited.

People felt the support they received from the service was effective. A relative said "The staff have the information they need but they do communicate with me. They are very good, I wouldn't have just anybody to walk through the door, my relative is precious, it has to be right.

People were supported to eat and drink where needed. One person told us that staff prepared them lunch and left any drinks or snacks that they wanted. Another person said" The carer comes and asks me what I want for lunch and then cooks it for me just as I like it. She waits until I have eaten, checks that I am comfortable for the rest of the day". One staff member said, "Most people I visit like simple meals which I prepare or I prepare a meal for the slow cooker whatever they wish".

People told us that staff supported them to maintain good health and health professionals were contacted on people's behalf if needed. One staff member said, "It's good seeing the same people because you can tell if they are not right, if they are not eating so much and you can ask then if you can contact their G.P.". Another staff member said, "I have gone to hospital with people when needed".

Good

Is the service caring?

Our findings

People and their relatives were happy with the staff that provided their care. One person said, "The carers are the most wonderful girls in the world". And a relative said, "The care of my relative is exceptional and the thoughtfulness that goes into helping me with any problems… they bend over backwards to help".

People said they were involved in planning and making decisions about their care and support. One person said "We were recommended AC Homecare and they gave me everything I needed to know. I am completely involved in planning of my relative's care, they are not able to communicate so everything comes through me".

People were treated with dignity and respect. One person said, "Yes they treat us with absolute dignity and respect". Staff spoken with could demonstrate how they maintained people's privacy and dignity. One staff member said, "I always make sure I keep people covered up as much as possible when I support them with personal care". Another staff member said, "It's really important to be respectful and treat people with dignity I always ask people before I do anything and make sure they feel comfortable and I always draw the curtains".

Confidentiality was promoted within the agency and staff spoke clearly of their responsibilities in maintaining confidentiality at all times. People's personal and private information was stored in a lockable cabinet and in a secure online password protected system. One staff member said "We have all the information we need about people on the app on our phone. We can only see the information of the people we are visiting we can't see anyone else information so it is all private".

Requires Improvement

Is the service responsive?

Our findings

People told us they had been involved in developing their care plans and, where appropriate, their relatives were involved too. One person told us "Yes, we were given all the information we needed and were involved in planning the care to make sure it suited our needs".

We looked at six peoples care plans and found that two care plans were not sufficiently detailed to be able to guide staff to provide their individual care needs. For example, One care plan stated "Care practitioners to administer medication, support with washing and dressing and preparing breakfast" but it gave no detail as to the persons preference and how they liked to be supported. Another care plan had stated, "Care practitioners are to support [person] with mobilising to the bathroom. Assist [person] in showering/washing whichever is their preference for that day". However, it did not say how they wished to be supported and the person was unable to tell staff. Personalised details are important to make sure people receive the care and support in the way they wish.

The other four care plans guided staff to support people in the way they wished. The provider, once aware of the lack of details in some care plans requested a review of all care plans and planned to do regular checks to make sure care plans reflected people's needs and personal preferences.

People told us that staff encouraged them to maintain their independence. One person said, "They do always communicate with me and encourage me in many ways, they make me feel like they care". One staff member said, "I always ask and explain what I plan to do and encourage people to do as much as they can".

People were aware of how to make a complaint should they need to. However, four of the ten people and relatives spoken with said that over the last few months it had not been easy to raise any issue as the manager had blocked them with their unhelpful and often aggressive manner. One person said, "The manager, who was sacked, took all my rights away, they made me feel worthless". They said they were on the brink of leaving the service but because of the care staff and the fact that the manager had gone they decided to stay. People said they had been told of the situation at the service and were now happy and encouraged by the openness of provider and senior staff and were confident any issue would be dealt with.

Requires Improvement

Is the service well-led?

Our findings

The registered manager left the company in January 2018. A manager was appointed the same month and was dismissed in August 2018. Although the provider undertook a three month review of the manager there were insufficient checks in place to identify the issues raised in the concerns and whistle blowing which prompted this inspection. The provider said they had been told the manager had applied for registration and had also informed the commission of the office move and other notifications. However, this was not the case and the manager had neither applied for registration with the Commission nor had they advised the Commission of the agency office move.

At our previous inspection on 26 May 2017 we found that people's risk assessments required more detail for staff to be able to support people safely. We also found the recruitment process needed to be more robust. Both areas still need work and the provider, once made aware of the need to improve, acted swiftly and set in place reviews.

There was a lack of training, supervision and regular meetings for staff all of which are necessary to guide and support staff in order that they can offer a safe and appropriate service to people.

There was not a consistent way of gaining people's feedback on the quality of the service. The provider said that staff had just begun a telephone monitoring service and improved the spot checks on staff at people's homes to also gain peoples feedback and suggestions.

None of the record keeping had been consistent, care plans were varied in details and effectiveness, there were no records of any complaints raised, staff records lacked information.

At this inspection we found a lack of audits and of systems which could help identify the issues raised. The systems that had been in place at the last inspection were reliant on the registered manager to complete the audits and checks. These had not been carried out since January 2018. And this had not been identified by the provider. This highlighted the lack of an overview of the service that the provider should have in place. The provider took responsibility for the lack of a robust system to review the running of the service and the quality of the service provided. They said how the events of the last month had been a steep learning curve with lessons learnt, shared and action identified and taken.

The provider did not operate effective quality assurance and auditing systems or processes. They did not maintain accurate, complete and detailed records in respect of each person using the service and records relating the employment of staff and the overall management of the regulated activity. These are a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities)

Since the initial day of the inspection the provider completed a significant amount of work to improve the service. They demonstrated clarity in identifying the issues raised and created an action plan to address them. The provider had been open and transparent with all people who used the service, the staff and with the Local Authority. The provider has employed a further care supervisor to help complete the action plans

and take the service forward. The provider plans to move from provider to become manager and register with the commission. The provider said he was now confident in the skills his staff had acquired and that staff now knew their jobs and what was expected of them for the good of the people they support.

People and their relatives were confident in the provider and the plans shared to improve the current situation. One person said, "They told us what happened and we have had to be taken on by someone else but we are looking forward to getting back to AC Homecare".

Staff had confidence in the provider and the open, clear direction and ethos they were promoting. One staff member said, "I had always liked working here we are like a family, it has been hard but we know it's going to be better again". Another staff member said, "I am very confident we will get through this. The provider knows what needs to be done, he is open to new ideas and change and is positive and passionate about the service for people. The provider said, "We want to promote and provide the best care we can for people, to be an open and transparent agency that encourages discussion with people so they tell us what not right or needs improving".

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 was a repeated lack of detailed assessments of activities or tasks that could pose a risk to people and a lack of a safe system of providing and recording medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective quality assurance and auditing systems or processes. They did not maintain accurate, complete and detailed records in respect of each person using the service and records relating the employment of staff and the overall management of the regulated activity.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems to check whether staff were safe to work at the service, were not used and staff were employed without any robust recruitment process.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The lack of appropriate support, training and supervision means that staff may not have had the skills necessary to support carry out their

role in supporting people.