Abicare Services Limited

Abicare Services Limited - Salisbury

Inspection report

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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
Abicare Services Limited – Salisbury provides personal care to people who live in their own home. The service provides visiting carers to people in Salisbury and surrounding areas, and also live-in carers to people throughout the south of England.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
The systems for managing medicines were not implemented effectively and increased the risk of harm to people. Records were not completed in full or kept up to date and did not give clear information to staff on the support people needed to manage medicines safely.

The service did not always take prompt action to keep people safe following allegations of abuse against staff. There were two occasions where live-in carers remained in post for several days following allegations of abuse.

New recruitment systems had been developed to improve the reliability of checks on people's identity and right to work in the UK.

Additional infection control systems have been developed as a result of the COVID-19 pandemic. People were happy with the measures staff were taking and said they felt safe.

The service had a range of quality assurance systems in place to review records and received feedback. However, the systems had not always identified shortfalls in the service provided or resulted in improvements.

There was mixed feedback from staff about the culture of the service and management support. Some staff felt they received good support, whilst others felt concerns about the management of the service were not taken seriously. Most of the concerns were raised by staff working in the live-in care side of the service.

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 13 December 2018).

Why we inspected
We received concerns in relation to staffing. As a result, we undertook a 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. You can see what action we have asked the provider to take at the end of this full report.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Abicare Services limited - Salisbury on our website at www.cqc.org.uk.

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Abicare Services Limited - Salisbury

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 visit was completed by two inspectors.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

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 announced. We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the registered manager would be in the office to support the inspection. Inspection activity started on 9 December 2020 and ended on 14 January 2021.

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 used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and seven relatives about their experience of the support provided. We spoke with nine members of staff and the registered manager.

We reviewed a range of records, including six people's support records and incident reports. A variety of records relating to the management of the service were 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 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.

Using medicines safely

● At the last inspection in October 2018 we identified improvements were needed to the way medicines were managed. Records of the support staff provided to people with their medicines were not consistent. At this inspection there were further shortfalls with the way medicines were managed, which increased the risk that people would be harmed.

● All five of the medicines management records checked during the inspection contained shortfalls. Staff had handwritten medicine administration records (MAR) for all five people, transcribing information from the dispensing label. Staff had not always recorded the strength of the medicine that had been prescribed or how frequently the person should be offered the medicine. The systems to check staff had not made any transcribing errors were not effective. This increased the risk that errors would result in people receiving the wrong dose of their medicine.

● Four of the five medicines records we inspected contained inconsistencies in the information recorded. The medicine recorded on the MAR did not match those recorded in the medicines risk assessment.

● Four of the five people were prescribed medicines to be taken 'as required' with no information recorded as to how staff should make the decision to offer this medicine. One person's MAR chart contained details of paracetamol and co-codamol, which had both been prescribed to be taken 'as required'. The medicines records did not contain information that co-codamol and paracetamol should not be taken at the same time due to the risk of overdose of paracetamol.

We found no evidence that people were harmed, however, systems to manage medicines safely were not effective. This was a breach of Regulation 12 (Safe care treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Actions taken in response to allegations of abuse did not always safeguard people. The provider did not have safe systems in place to replace live-in carers promptly when there were allegations of abuse. There were two examples where allegations of abuse had been made against live-in care staff, yet the member of staff had remained in the person's home for several days until they could be replaced. In both incidents the provider reported the allegations to the local safeguarding team and, once removed, the staff were suspended from duty pending the investigation outcome.

● In one incident where there was an allegation of restrictive practice and possible verbal abuse, the member of staff remained as a live-in carer for a further four days from when concerns were first raised about their practice, and two days from when their manager observed them restricting a person's freedom of movement. Records demonstrated a supervision meeting was held with the member of staff and phone

calls and a visit were made to them. However, at other times during the four days from when concerns were first raised about their practice, the member of staff was alone with the person without any supervision.
● In another incident there was an allegation that a member of staff shouted at, pushed and restricted a person. The member of staff remained as the person's live-in carer for a further four days until they were removed.
● One of the community service managers, responsible for local management of live-in carers told us, "With safeguarding, we sometimes struggle to find a carer to replace someone when there has been an allegation of abuse. We try to replace the carer as soon as possible, but it may go into the day after before we can replace them. When this has happened, we have monitored with phone calls." Another community service manager said they report any concerns to the safeguarding team and try to find replacement cover the same day, although sometimes it may take longer.
● Although recruitment of new live-in care staff cannot be completed immediately, the systems to replace staff subject to an allegation of abuse on a temporary basis were not always effective. Some measures had been taken to manage these risks, however, staff who had allegations of abuse made against them remained working alone in people's homes with no direct supervision.

We found no evidence that people were harmed, however, the systems to safeguard people were not effective. This was a breach of Regulation 13 (Safeguarding service users from abuse an improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● Risk assessments had not always been kept up to date when people's needs changed. Examples included medicines listed on people's medicine administration records that were not included in their medicines risk assessments. There was also a bathing risk assessment for one person which stated there was no catheter care that was needed to be provided by staff. The daily care records for this person demonstrated staff were providing catheter care, following the person's recent hospital stay. There was no information available about the care staff should provide or signs of a problem that staff should monitor.
● Three of the four community service managers we spoke with said they found it difficult to keep risk assessments and care plans up to date due to their workload. They said they did have regular contact with care staff and discussed changes to people's care needs, but this was not always reflected in the records.
● Most people who were receiving care, and their relatives, said they felt safe and happy with the way staff were working.

Staffing and recruitment; Learning lessons when things go wrong
● The service had been subject of a recent Home Office and safeguarding investigation into staff who did not have the right to work in the UK. As a result of the investigation some care staff had been removed from the service and replaced. The registered manager reported this had been a difficult process which had caused disruption to the care people received.
● As a result of the investigations, new recruitment systems had been developed to improve the reliability of checks on people's identity and right to work in the UK.

Preventing and controlling infection
● The service had developed additional infection control procedures as a result of the COVID-19 pandemic. Staff had received additional training and there was a good supply of suitable personal protective equipment (PPE).
● People told us they were happy with the measures staff were taking to keep them safe.
● A risk rating system had been developed to ensure staff could respond to changing circumstances in relation to COVID-19 and work in a safe way.

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 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; Continuous learning and improving care

- Quality assurance systems had not always identified shortfalls in the service provided or breaches of regulations. Improvements identified as needed at the last inspection had not been made.
- The registered manager was aware the response to replacing live-in carers when there was an allegation of abuse had not always been effective. During the inspection the registered manager told us an incident that occurred on 10 November 2020 was "Definitely one where the staff should have been removed straight away." However, a further allegation against a live-in carer on 19 November 2020 resulted in a similar delay, with both live-in carers being left in post for several days following the allegation.
- The quality assurance checks had identified medicines management records were not always completed correctly. Staff had been reminded of their responsibilities in meetings.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

- There were mixed views from staff about the culture of the service and support they received from the management team.
- Five of the nine staff we spoke with gave negative feedback about the management team and felt they were not given the support they needed to do their job effectively. Concerns raised by staff included a lack of clear communication from the management team, a lack of confidence in the response they would receive if they raised concerns and a lack of support from management when they were struggling with their workload. Most of the concerns were raised by staff working in the live-in care side of the service.
- Other staff told us they received good support and were happy with the management of the service.
- The provider completed surveys of staff to identify any areas of concern and had developed well-being action plans to support staff. One member of staff told us this had been a particularly welcome initiative during the past year when they were dealing with the COVID-19 pandemic.
- The registered manager was aware of their responsibilities under the duty of candour.

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

- The service involved people, their families and others effectively in a meaningful way. Most people said they could get hold of the management team if they needed to and said they received visits to check how

things were going. People said the management team worked with them to resolve problems.

● The registered manager responded to issues raised in quality surveys and let people know what action they had taken. Additional meetings had been arranged where people had expressed concern to gain a greater understanding of the problem and find solutions. The management team had worked with health teams where people had expressed views about the service provided by visiting professionals.

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 The registered manager had not ensured there were effective systems in place for the proper and safe management of medicines. Regulation 12 (2) (g).

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager had not ensured systems to protect service users from abuse and improper treatment were operated effectively. Regulation 13 (2).