Acquire Care Ltd

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Inspection report

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Date of inspection visit:
19 February 2019

Date of publication:
29 April 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?	**Inadequate**

Summary of findings

Overall summary

About the service:
Acquire Care Ltd is a domiciliary care agency that was providing personal care to 86 people at the time of the inspection.

People's experience of using this service:
We identified five breaches of regulations. These were in relation to safe care and treatment, safeguarding procedures, mental capacity, good governance and the registered managers responsibilities.

People were satisfied with the day to day support they received from the staff that visited them. However, their call times were not always planned in line with their wishes. This impacted negatively upon peoples' wellbeing.

The overall governance of the service was not robust and had failed to ensure that people received a service that was in line with their wishes. It had failed to ensure that issues were not only dealt with but that subsequent improvements were sustained.

People were not always supported to have maximum choice and control in how they wanted their support to be delivered.

Staff received adequate training and support. People were confident in the ability of staff to provide the support that they needed.

More information is in the detailed findings below.

Rating at last inspection:
Good, report published 25 September 2018

Why we inspected:
We undertook an unannounced responsive inspection of Acquire Care Ltd on 19 February 2019. This inspection was carried out in part following concerns that had been raised by the public surrounding the standard of care delivered by Acquire Care Ltd.

Enforcement:
You can see what action we told the provider to take at the back of the full version of the report. Please note that the summary section will be used to populate the CQC website.

Follow up:
We will monitor all intelligence received about the service to inform the assessment of the risk profile of the service and to ensure the next planned inspection is scheduled accordingly. We have requested an action

plan from the registered provider as to how they plan to address breaches in regulation and make improvements to the service.

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 effective? The service was not always effective Details are in our Effective findings below	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our Well-led findings below.	**Inadequate**

Acquire Care Ltd

Detailed findings

Background to this inspection

The 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 team consisted of three inspectors and an expert by experience (ExE). 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:
Acquire Care Ltd is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to 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:
This inspection was unannounced.
We visited the office location on 19 February 2019 to see the manager and office staff; and to review care records and policies and procedures.

What we did:
Before the inspection we reviewed the information, we held about the service and the service provider. The registered provider completed a Provider Information Return (PIR). 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. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law.

We spoke with 11 people and five relatives. We looked at records, which included seven people's care and

medicines records. We checked recruitment, training and supervision records for four staff. We looked at a range of records about how the service was managed. We also spoke with four staff members, the registered manager, the operations manager and the care manager.

Requires Improvement

Is the service safe?

Our findings

Safe – 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.

Using medicines safely:
● The medicines management was not based on current best practice. For example; where there were handwritten entries on Medicine Administration Records (MAR), these were not signed by the staff member completing the MAR or countersigned by a second signatory as per national guidance. Without the MAR being countersigned the registered provider could not be certain that the information recorded on it was accurate.
● Peoples care plans did not always contain accurate up to date information in relation to their medicines. One person had details of a medicine that was prescribed once a week. This medicine was not recorded on the person's MAR. During our inspection we asked the manager on two separate occasions to evidence if the person was receiving this medicine or not. We did not receive this information.
• Medicines were not managed safely and in line with The National Institute for Health and Care Excellence (NICE) guidance Managing medicines for adults receiving social care in the community, in that staff competencies, in relation to the administration of medicines were not being assessed.

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

Systems and processes to safeguard people from the risk of abuse:
• The provider had safeguarding policies in place and copies of both the local authorities' (they worked with) safeguarding procedures were available in the office.

Learning lessons when things go wrong
• The provider had systems in place to monitor incidents. However, these systems were not always effective. For example, we saw an example of where the provider had recorded a medicine error within a 'meds error' book. We saw evidence of how this medicine error had resulted because of a missed visit. This missed visit was not recorded within the system for recording missed visits. Therefore, the systems in place were not always effective as they did not always enable the provider to take action to minimise risks and prevent things from happening again.

Assessing risk, safety monitoring and management:
• Risks to people's well-being were assessed, recorded and updated when people's needs changed.
• People's risk assessment included areas such as their mobility, skin integrity or medicine management.
• Staff were familiar with and followed people's risk management plans.

Staffing levels:

•There was enough staff to support people's needs.
• People were protected against the employment of unsuitable staff as the provider followed safe recruitment practices.

Preventing and controlling infection:
• The provider ensured staff were trained in infection control. People told us staff washed their hands and used disposable gloves and aprons where required.

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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".
People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA

Ensuring consent to care and treatment in line with law and guidance:
•□At the last inspection we made a recommendation to the provider in relation to MCA.
•□At this inspection we found care records were not always completed in line with the principles of the act and people's rights were not always protected. One person's care plan stated that a family member made decisions on behalf of the person. However, the relative had no legal authority to make decisions on the person's behalf.
•□Staff completing risk assessment forms had stated "Not qualified to assess capacity or comment on how to prevent any risks associated with service users' capacity. This is not in line with MCA codes of practice.
•□Records relating to people's capacity to make decisions were not always clear. One person's records had errors and these had been crossed out. However, it was not possible to tell from the record whether the person had capacity to make the decision on the form.

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
•□People's needs were assessed prior to them using the service to ensure needs could be met. Assessments took account of current guidance. People's communication needs were identified in line with Accessible Information Standards.

Staff support: induction, training, skills and experience
•□Staff completed a range of training when they started working at the service and had regular refresher training. This was a combination of face to face training, e-learning and completing workbooks. However, there was no clear process to support staff who failed to pass assessments.
•□Staff were monitored through regular spot checks.
•□There was no clear system to ensure staff were supported to improve their practice. A member of staff

had made a medicines error. There was no evidence of a performance improvement plan to ensure the member of staff was supported to improve.

Supporting people to eat and drink enough to maintain a balanced diet
•□Where people required support with food and drink, this was detailed in their care plans. This included details of special dietary requirements.

Staff working with other agencies to provide consistent, effective, timely care
•□The service worked with the social and healthcare commissioners to ensure people were assessed and supported to remain in and return to their own homes in a timely manner.

Supporting people to live healthier lives, access healthcare services and support
•□The service worked closely with health care professionals. One person had difficulty transferring from their bed. The manager had arranged a meeting with the person's family and the occupational therapist to identify how this could be improved.

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity.
• Care plans did not always consider people's needs in relation to protected characteristics. One person's care plan referred to their 'culture' however, there was no information as to how this may affect the person's care delivery.
• People and relatives' comments about the reliability, continuity and consistency of care visits indicated that they were not always well supported. Times were not consistent with a person's wishes around morning, lunch, tea or night routine. One person told us, "There are four visits at seven, noon, five and nine, but often they are late.; We could live with up to 30 minutes late but Acquire Care has told us they can't guarantee to match those times".
• People were keen to stress that carers were kind and caring and any deficiencies in the standard of care were described as due to poor organisation and management of the service, comments about staff were complimentary. One person told us, "The carers are all very good and I get on well with most of them". A relative said, "Yes, the care and the carers are good, Mum gets on well with the carers".

Respecting and promoting people's privacy, dignity and independence.
• Some people and their relatives felt their dignity and privacy was compromised due to inconstancy in care staff. Comments made included, "They kept sending me men when I didn't want them", "The Manager at the time knew we didn't want a man to do the personal care but they kept sending men for ages and even put it in the Care Plan that she likes and wants male carers" and "They kept sending me men when I didn't want them".
• Care plans were written in a respectful manner.
• Personal records about people were stored securely and only accessed by staff on a need to know basis. Staff understood their responsibilities for keeping personal information about people confidential.

Supporting people to express their views and be involved in making decisions about their care
• Care plans were completed with people and their relatives to ensure they reflected people's wishes.
• People and family members told us that they were asked their views and opinions about the care. They told us that senior care staff did this during review meetings and during general visits to their home and over the telephone.
• Review Care questionnaires which were sent out to people and family members throughout the year also provided them with an opportunity to express their views about their care.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Where people's needs or conditions changed there was not always evidence that changes had been reported and action taken. For example, one person's daily record identified the person had a change in the condition of their catheter. There was no record of this being reported to the office or to a health professional. This had resulted in the person experiencing some distress as the issue had not been rectified.
• Reasonable adjustments were made where appropriate that ensured the service identified, recorded, shared and met information and communication needs of people with a disability or sensory loss, as required by the Accessible Information Standard.
• Care plans detailed people's support needs and how people wanted their needs to be met.
• Care plans did not always contain information about people's interests or life histories to enable staff to know them well. The registered provider completed a Provider Information Return (PIR). 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. Within this document the provider had clearly stated that "People are supported to follow their interests and take part in social activities and, where appropriate education and work opportunities" and "Encourage and support people to develop and maintain relationships with people that matter to them and avoid social isolation. However, there was no evidence of this in peoples care plans.
• There were regular reviews with people to ensure their care needs were being met.

Improving care quality in response to complaints or concerns
• Complaints were recorded. However, complaints were not responded to in line with the providers policy. One relative had complained about the standards of care. The manager had responded to the complaint but there was no evidence of an investigation or lessons learnt.
• Complaints were around the continuity and reliability of the care and attitude of some staff. Where complaints had been investigated, people were all not confident that changes were maintained. CQC had received a number of complaints in respect of the same issues leading up to the inspection.
• People and families felt able to address some issues with the staff directly. One person told us "They seem to take on board anything you want".

End of life care and support
• At the time of our inspection no one at the service was receiving end of life care. However, people's care records contained advanced wishes. For example, some care plans contained details relating to people's wishes not to be resuscitated in the event of a cardiac arrest.

Inadequate

Is the service well-led?

Our findings

Well-Led – 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.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility.
• The CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The registered manager had failed to meet these specific requirements. For example, we reviewed an incident that involved a person being given medicines which they should not have received. Although the registered manager gave assurances that they had met with the person and their family, they could not provide evidence of reasonable support being provided to the person or their family and they had failed to provide a written apology to the person. This meant that the registered manager had not acted in a transparent manner.

This demonstrates a breach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered manager was not clear about their responsibilities in line with regulatory requirements such as reporting to CQC or concluding disciplinary matters if a staff member had resigned.
• The registered provider must submit to us notifications of key events in the service such as deaths, safeguarding incidents or serious injury. We found that the registered manager had failed to notify the CQC of situations involving serious allegations of neglect in a timely manner. This meant that the CQC was not able to monitor these events that affected the health, safety and welfare of a person using the service.

This demonstrates a breach of a breach of Regulation 18 of the Care Quality Commission (registration) Regulations 2009.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
• The service had submitted a notification relating to the death of a person using the service. However, this notification mentioned a serious meds error which happened seven days previously. The registered manager was unaware that the wrong notification was submitted to CQC. This meant that the registered manager did not have oversight of statutory notifications.
• Following this medication error, the registered provider carried out a full investigation, however, the registered provider failed to notice that the staff member involved had disclosed that they had carried out similar practices with another person, this was not investigated further and the registered manager was unaware of it until it was point out by CQC. We asked for the training and competency forms to demonstrate

that the staff member had received the correct training for this client. The register manager was unable to provide these.

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

Continuous learning and improving care.
• The service had an electronic telephone monitoring system to manage care visits. The system logged staff in and out of people's homes and alerted the provider if staff were late. We looked at records within the monitoring system and we identified instances where incomplete calls or late visits had taken place, the registered manager was able to explain why these instances had happened. However, we identified an instance where a visit had been recorded as being carried out but in fact had not. This had been manually entered onto the system despite evidence that demonstrated the management team were aware that it hadn't taken place. The authorisation to do this had been given by a member of the management team. This meant that important records relating to peoples care were not accurate.
• There was an absence of effective systems to enable the provider to have an oversight of the quality of the service. The issues relating to the safety and wellbeing of people using the service, found during the inspection had not been identified. For example the concerns relating to; medication practices, inaccurate records in relation to staffing, complaints not always being responded to in line with the providers policies and procedures, care records not always containing person centred information, MCA, the non and inaccurate reporting of a statutory notifications, safeguarding procedures and the duty of candour.

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

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others.
• People, family members told us the management team were available to provide advice and guidance but felt they did not always have a honest response. Comments included "They tell lies to cover themselves. I don't like the Management style", "One Friday night they didn't come at all. We phoned up to see why and they said the carers just forgot. When we asked the carer later (they) said the problem had been the schedule, it was not consistent and was often being changed at the last minute", "We think that Acquire tell lies" and "They lie to protect themselves".
• People were concerned about the impact work had on the staff: their comments included, "We have overheard carers criticizing their supervisors", "The staff are often stressed at being messed around", "I don't like it that the girls have all the pressure. Lots of them leave and I don't think they are treated right, the schedules are too tight" and "I wish that [registered manager] treated his staff with more respect. Staff are always complaining that management keep changing the schedules and moving visits at the last minute".
• There were a number of processes in place to obtain the views and opinions of people and family members about the service. We saw that some of these views were positive.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had failed to notify the CQC of situations involving serious allegations of neglect in a timely manner.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not follow the principles of the Mental Capacity Act

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The medicines management was not based on current best practice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was an absence of effective systems to enable the provider to have an oversight of the quality of the service.

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered manager had not acted in a

transparent manner following an incident