Access Care Solutions Limited

Access Care Solutions

Inspection report

Suite 6, School House Business Centre
London Road, Alvaston
Derby
DE24 8UQ

Tel: 01332409477
Website: www.accesscaresolutions.co.uk

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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

About the service
Access Care Solutions is a domiciliary care service. It provides care for people living in their own houses and flats in Derby and Derbyshire. People are supported in their own homes so that they can live as independently as possible. CQC regulates the personal care and support. There were 13 people who received personal care at the time of the inspection. 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
Medicines were not always managed in line with good practice and records did not show people had always received their medicines as prescribed. Care plans contained details of what care people required however, there was limited information on other health conditions that people had and whether these had an impact on how care was provided. Not all the required pre-employment checks had been completed on staff when they started work. Checks to help ensure the quality and safety of services were not effectively operated. Records were not always complete or accurate.

People's communication needs were assessed, and the provider told us they were able to provide information in different formats. Some relatives told us they would prefer access to their family members care plans and records in a non-digital format and they felt this option had not been presented to them. As such, some relatives did not feel fully engaged with the service. Other relatives spoke highly of their involvement and praised the communication with the service.

Care staff had been trained to understand how to support people with their end of life care needs. However, care plans for people's end of life care contained limited information and did not record whether people had declined to discuss this issue.

People were supported to have maximum choice and control of their lives and care staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, people's care records did not always accurately reflect what the provider told us about their capacity to understand their care.

There were enough staff to meet people's needs and people received care from consistent care staff. Risks were assessed and actions had been identified on how to reduce these. This included how to reduce risks from infection, including from COVID-19. Staff were clear on what actions they needed to take, including the wearing of personal protective equipment (PPE). Systems were in place to help reduce the risks to people from abuse. Care staff had been trained and understood how to identify signs of potential abuse and how to report their concerns to help keep people safe.

Care staff told us they had received training to enable them to work effectively. Care plans for people's

nutrition and hydration needs were in place as needed. The involvement of other agencies in people's care was effectively managed.

People felt well-supported and cared for with dignity and respect. People's decisions about their care were respected and their choices and control promoted. People's independence was supported.

People received a service that adapted to meet their changing needs. The service worked to help prevent people feeling socially isolated and care staff developed positive relationships with people. Systems were in place to help ensure any complaints were dealt with effectively and in line with the provider's policy and procedures.

The provider looked to investigate any concerns raised with them and was considered open and approachable by care staff and relatives. The provider worked in partnership with others to achieve good outcomes for people.

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

Rating at last inspection
This service was registered with us on 19 November 2020 and this is the first inspection.

Why we inspected
This was a planned inspection based on the date of registration.

Follow up
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 effective?

Requires Improvement

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was 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.

Access Care Solutions

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
This inspection was completed by two inspectors.

Service and service type
Access Care Solutions is a domiciliary care agency. It provides personal care to people living in their own houses, flats and specialist housing in Derby and Derbyshire. The service was supporting 13 service users with personal care at the time of the inspection.

Registered Manager
There was not a registered manager at the time of this inspection. The nominated individual who was also the provider was in the process of applying to become the registered manager. Both the provider and the registered manager 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 two days' notice of the inspection. This was because we needed to be sure that arrangements could be made for us to review records in the office.

Inspection activity started on 30 August 2022 and ended on 8 September 2022. We visited the office location on 30 August 2022. Phone calls were made to six relatives on 1 September 2022. We made phone calls to care staff on 2 September 2022. We continued to review evidence the provider sent us until the 8 September 2022.

What we did before the inspection

We used information received about the service since it registered with the Commission. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six relatives of people who used the care service. We spoke with the director, who was the nominated individual, and a senior carer. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with an additional three care staff on the telephone.

We reviewed a range of records including the relevant sections of three people's care records and two people's medicine administration record (MAR) charts. We looked at three staff files in relation to recruitment. We reviewed other records related to the management and governance of the service, including policies, staff training records and how checks were made on the quality and safety of services.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. 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

● Medicines management was not always in line with recognised good practice. Medicines administration record (MAR) charts had gaps. This meant it was not always possible to tell if the medicine had been given and not recorded, missed, refused, or if that there was another reason, such as whether it was unavailable. The provider was unable to demonstrate people received their medicines as prescribed.

● Records showed where one person had been given paracetamol without leaving the required four hour gap between administrations.

● Records showed, and the provider confirmed, one person's medicines had been unavailable at times and their relative was responsible for ordering and collecting their medicines. Daily notes did not record what actions had been taken by care staff to liaise with relatives to ensure this person received their medicines as prescribed.

● Medicines administration record (MAR) charts were not in place to record people had been given their skin creams as prescribed. Instructions on where people required their skin creams were not always clear. This placed people at risk of inconsistent care.

People had not always received their medicines as required and medicines were not always managed safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care staff were trained in medicines administration and their competence to do so had been checked. However, they only checked a limited number of areas and did not check what actions care staff were required to take in different and foreseeable situations, such as medicine being unavailable.

Staffing and recruitment

● Most, but not all, of the required pre-employment checks on care staff had been completed. For example, not all care staff had provided a full employment history. There was not always evidence to show the provider had sought to understand gaps in care staffs' employment history and why their employment had ended, as required.

● Other pre-employment checks had been completed. For example, Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer.

● Relatives mostly told us care staff would arrive in line with their expectations and on occasion, if care staff were late, they would receive a phone call to explain. Records showed where relatives had raised concerns over care call times, these had been investigated and resolved by the provider. However, some relatives told

us they did not know what times care calls had been planned for and so were not sure as to whether care staff had been on time.
● One relative told us staffing was consistent, they said, "It's nice to have the same carer, they are more familiar to my [family member]."Care staff told us they had enough time to care for people and travel between calls without feeling rushed. The provider told us they monitored care call times to ensure they were timely and would only take on care calls if they were certain they had the required care staff available. This meant there was sufficient staff to meet people's needs.

Assessing risk, safety monitoring and management
● Care plans contained clear details on the care people needed and how this was to be provided safely. However, there was limited information available for staff to understand about people's identified health conditions and how these impacted on the person's care and well-being. For example, care plans identified a person had chronic obstructive pulmonary disease but did not describe how much this affected the person and whether anything associated with this condition would affect how care needed to be provided.
● Information on how to reduce risks was included in people's care plans. For example, details of what equipment was needed to help people transfer safely had been identified, such as slide sheets to help re-position people safely in bed. This helped reduce risks to people.
● Risk assessments for working in people's homes had been completed. Care staff had received training to understand risks and risk assessment. In addition, they received training on fire safety and emergency first aid. These measures helped to reduce and mitigate risks to people and staff.

Preventing and controlling infection
● Staff understood how to reduce risks associated with infections, including those from COVID-19. Care staff had been trained in infection prevention and control and spot checks were completed to ensure staff complied with good practice guidance.
● Policies and procedures used by the provider reflected the latest government guidance. Care staff had completed testing for COVID-19 and the provider was aware of forthcoming changes to this requirement. The provider had secured sufficient quantities of personal protective equipment for care staff to use.

Systems and processes to safeguard people from the risk of abuse
● Care staff had been trained and understood how to identify and report signs of potential abuse or harm. The provider had safeguarding policies and procedures in place that were accessible to staff to help support the reporting of any concerns.
● Records showed the provider had worked with the local authority safeguarding team when required to investigate any safeguarding concerns. There were no outstanding safeguarding concerns at the time of our inspection.

Learning lessons when things go wrong.
● Care staff reported any accidents or incidents and these were reviewed by the provider to learn lessons and reduce further risks. For example, following a fall a person was re-assessed and provided with additional equipment to help them transfer more safely.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant 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 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 when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

- The provider told us people had capacity to understand the care they received. However, some information in people's care plans was contrary to this. For example, one person's assessment stated they did not have the capacity to understand their medicines and finances and there was no further mental capacity assessment or best interest decision making recorded. The provider told us they would review these records to ensure they were accurate.
- Care staff had been trained in the MCA and understood how to check that people consented to their care. Care plans included prompts to ensure people were asked and gave their consent. One care staff told us, "We ask for consent before we start care."
- Policies were in place to help the service work within the principles of the MCA. This helped to ensure people's rights were respected.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Risk assessments were in place and covered areas such as falls, moving and handling, medicines. Where risk assessments used 'scores' to indicate risks, they had not always been fully completed. For example, with medicines and falls risk assessments. This meant assessments were not always used to their full effectiveness.
- Assessment processes were able to reflect people's equality characteristics if they choose to discuss these. One relative told us, "We have no religious or cultural needs but if there had been any we could have discussed them." This helped to ensure care could meet people's needs and help to prevent discrimination.

Staff support: induction, training, skills and experience

● All care staff told us they felt supported to have the training, skills and experience needed to work effectively. Records showed staff were trained in areas relevant to people's needs, such as pressure sore prevention, moving and assisting people, end of life care and person-centred dementia care.

● Staff received structured support to work effectively. Care staff told us, and records confirmed, they had appraisals and supervision with the provider. This enabled care staff to have the opportunity to reflect and learn from their practice, receive personal support and professional development.

● From 1 July 2022 all care staff are required to receive training on how to interact appropriately with people who have a learning disability. The provider told us additional training to meet this requirement had been planned and was to be completed at the next team meeting.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported with their nutrition and hydration needs. People's care plans detailed any care they required with their meals and drinks. Any food allergies were recorded in care plans as well as any known preferences. Care staff had been trained in nutrition and well-being.

● Care staff told us they would ask people for their choices of meals and drinks. They told us they would also leave people with snacks and drinks between care calls. This helped people keep themselves hydrated throughout the day.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The provider worked effectively with other agencies to provide continuity of care. The provider told us one person's care had had various changes in how it had been commissioned over a period of time. The provider had worked with commissioners to ensure they could continue to provide care to the person to ensure continuity for them.

● Relatives told us care staff informed them if they thought people were not feeling well so they could arrange for them to be seen by a healthcare professional. One relative said, "Care staff will always let me know such things as if [person] is more tired than usual and has rang me to say [person] is a bit unwell so I can get the GP to see them."

Good

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.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were well supported. Relatives told us the care staff and the provider were caring. One told us, "[Person] adores them, [Name of worker] has a good way with them and [person] trusts them." Another relative said, "From the outset they've been really good, the level of care to [person] is incredible."
- Assessments reflected what was important to the person and their life histories. This helped to build caring relationships between people and care staff. Care staff told us they enjoyed their work and spending time talking with people. One care staff told us, "We chat about how their days been and if they are sleeping well."
- The provider had equality and diversity policies in place. Care staff had been trained in equality, diversity and inclusion. These actions helped to promote equality and diversity and reduce discrimination.

Supporting people to express their views and be involved in making decisions about their care

- Care plan assessments and reviews of care enabled people to express their views. People's views and decisions were recorded and known. Relatives were involved where appropriate. One relative told us, "I've seen the care plan, it's reflective of [person's] needs and I can review it."
- People's involvement in their care was promoted. For example, care plans stated care staff should talk about what would happen next when providing care to enable the person to be as involved as possible. Care staff provided examples of how they worked in ways to promote people's involvement. For example, one care staff member told us, "I make sure I ask them is everything ok before I leave."

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was respected. One relative told us, "[Care staff] seem respectful to [person] and their home and their wishes." The provider had a dignity policy in place and care staff had been trained in dignity and respect. Care staff told us how they promoted people's privacy and dignity. One care staff told us, "For people's privacy and dignity I shut curtains on care calls [When providing personal care]. We follow their wishes especially for personal care and cover people with towels."
- People's independence was promoted. Care plans identified what people could do independently and how care staff could continue to support people with this. Where people used equipment to help with their mobility, such as use of a walking frame, this was reflected in their care plans. These actions helped to promote people's independence.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated as requires improvement. This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Some relatives told us they would prefer information on their family member's care plans and records in a non-digital format. The provider told us they could provide this information in different formats and that they asked relatives at care reviews if they had any issues with the information format used. However, some relatives did not feel the non-digital option had been offered to them.
- People's communication needs were assessed to identify if people required information in different formats. For example, the provider's initial assessment of people's needs asked what language people preferred to use.

End of life care and support
- The provider told us they would sensitively ask about people's end of life care wishes and that not everyone wished to discuss this. However, there was limited evidence to show people had been asked about their end of life care planning and how care staff could best support this. The provider told us they would review and record these discussions or people's decisions to decline discussions more fully.
- Care staff had been trained in this area of care and understood how other professionals, such as district nurses and GP's were involved in people's care.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
- Care was kept under review to ensure it remained responsive. One relative told us, "I can get the care plan changed and reviewed and they are good at being approachable. If we need extras [provider] is good at getting them sorted." Another relative told us, "There are reviews yes, I've recently gone through this with them and reviewed the care."
- The service was able to respond responsively to changes. One relative told us, "The level of communication has been incredible, I've rang [the provider] at all times and they've stepped in to cover if I can't get when I should be going." This helped people receive continuity of care.
- People received personalised care. Care staff told us they would always ask people for their choices. One care staff told us, "I always ask people what [drinks and snacks] they want me to leave out for them."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them.

● Care staff understood how to reduce social isolation for people. One care staff told us, "I have regular clients and we can chat, and they can share their experiences and their lives and work." One relative told us, "[Person] has developed a good relationship with [care staff.]" Another relative told us, "[Care staff] are friendly."

Improving care quality in response to complaints or concerns

● Systems were in place to help feedback improve care quality. Where complaints had been received these had been recorded and actions taken to improve the quality of the service. For example, improving care call timings.

● A complaints policy was in place and relatives told us they understood how to complain if they needed to. Most but not all, relatives told us they felt comfortable to complain. There were no outstanding complaints at the time of our inspection.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- Systems and processes to check on the quality and safety of services were not operated effectively. The provider's audit policy identified monthly quality checks should be completed on a range of areas. These included, amongst others, audits on medicines management and care documentation. These had not been completed and as such the provider had not identified the shortfalls we found with medicines and care records. Therefore, they had not identified how to improve the service. This meant the provider was not effectively managing quality performance or had oversight of risks and regulatory requirements.
- The provider had completed checks on the electronic care records used in the service. These identified some entries were missing and that care staff had been informed. However, the daily records we reviewed still had days when care visits had not been marked as completed. This meant the action taken to remind staff had not led to improvements being sustained.
- Records were not complete. Records for the administration of topical medicines were not kept. Some daily visit records of the care provided to people had not been completed. Records of who attended and what was discussed at staff meetings were not made. Recruitment records did not always contain the complete information required. This meant the provider was unable to produce a complete record of the care people received and some records for the running of the business were also not complete.
- Records were not always accurate. Information in people's care plans was sometimes contradictory. For example, mental capacity assessments indicated a person did not have the capacity to make decisions on medicines and finances. However, the provider told us they did have capacity and their care record was incorrect.

Systems and processes to assess, monitor and improve the quality and safety of services and reduce risks were not operated effectively. Records were not always accurate or complete. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2014 (Regulated Activities) regulations 2008.

- The provider told us they would make plans to complete audits in line with their existing policy. Prior to our inspection they had arranged for an external consultant to complete some audits on the service to provide external scrutiny. These were scheduled to commence in September 2022.
- The provider had taken reasonable steps to secure a registered manager. An application for the position of registered manager had been submitted to CQC and this was being processed at the time of the inspection. The provider told us an office manager had been recruited was due to start work in the

immediate future. They told us this would help them make the improvements they wanted to see with records.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Some relatives told us their involvement and engagement in the service was limited because they preferred to have information on their family members' care provided to them in a non-digital format. In addition, they had not received any paper based 'Welcome pack' with information about the service. Other relatives told us they did have this information and felt fully involved. One relative told us, "There is a welcome folder in the house and an on-line app. I can see what times they have gone in and what has been done; I can always check on the app."

● Most relatives were positive that the service provided good, reliable person-centre care. One relative told us, "They've done exactly what they said they would do, they do all the medicines and not missed anything, and they've been at the right time."

● Care staff told us they felt fully involved and valued working at the service. Their comments included, "[Provider] is really good, I love this company, I really like it. They are all very friendly. [Provider] is there for us 24/7. They always answer calls and meet with us face to face. I can ring them at night-time, and they will always answer." Another care staff said, "I love it, [provider] is kind and lovely." Staff meetings were held, and we observed care staff call into the office throughout our inspection. The provider had taken steps to ensure care staff were confident to contact them for support and that they felt engaged and involved in the service.

● People and staff had been asked for their feedback on the service and this had been reviewed by the provider. The provider had taken actions to help resolve any queries raised.

Working in partnership with others

● Other health and social care professionals were involved in people's care and the provider worked in partnership. For example, the provider had requested reviews of people's mobility and had requested additional equipment, which had been provided.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider demonstrated an open and honest approach when investigating concerns raised with them. One relative told us, "They dealt with [one issue] and they do apologise if something is not right."

● The provider had a duty of candour policy in place. This helped to ensure any investigations into when things had gone wrong would meet the legal requirement to be open and honest.

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 Medicines were not always managed safely. Regulation 12(1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not always operated effectively to assess, monitor and improve the quality and safety of services and assess, monitor and mitigate risks. records were not always accurate or complete. Regulation 17(1)