Annette's Care Limited

Annette's Care Limited Domiciliary

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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: Annette's care is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older adults and younger adults who may have a physical or learning disability or a mental health need.

The service is also registered with the commission to provide care to people housed under supported living arrangements. However, at the time of the inspection, the agency was not supporting anyone under this arrangement.
Rating at last inspection: Requires improvement (6 March 2018)
At the last inspection we found the provider had not always acted to keep people safe. People's medicines were not always managed safely. The provider had not always assured themselves new staff were suitable to work with vulnerable people. The provider had not ensured systems and processes were in place to monitor the quality of the service and staff practice. Concerns raised or identified had not always been used to improve the service. The provider had failed to notify us of all significant events in line with their legal obligations.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of 'safe' and 'well led' to at least good. The provider assured us they had already put processes in place to ensure improvements were made.

Why we inspected: Concerns about the service had been raised with us by whistle-blowers, people and relatives, so we decided to inspect the service earlier than required. The concerns included staff providing care to people before checks had been completed to ensure they were safe to work with vulnerable adults; staff providing care who had not received appropriate training; people not receiving their calls at the correct time or for the correct amount of time, or calls being missed without notice; records being falsified; people who need the support of two staff members to move safely, receiving support from only one member of staff; and staff not ensuring people's medicines and health needs were met.

People's experience of using this service:
- People did not receive a service they could be assured was safe.
- People received care from staff who had not all been trained appropriately.
- People's needs were not assessed promptly when they started to use the service. People did not all have records in place that described how they wanted and needed to receive their care.
- The providers were not always open and honest. They had assured us all staff providing care had been recruited safely and trained appropriately. This was not always the case.
- The providers were not up to date with best practice and were not aware of all regulations and legal requirements.
- The providers had not checked the quality of the service effectively.
- New people continued to be accepted to the service even though the providers were having to cover care

visits and some people did not have care plans in place.
•□Staff did not always feel supported in the role.
•□Staff cared for people. People felt staff kept them safe and were responsive to their needs.

More information is in the full report.

We asked the provider to ensure that no staff who had not been recruited safely were enabled to support people. We also reported our concerns to the local safeguarding authority.

Enforcement: We found breaches of regulation. Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up: The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our Effective findings below.

Inadequate

Is the service caring?

The service was 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

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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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: Three inspectors and one expert by experience, who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: Domiciliary care agency
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger adults who may have a physical or learning disability or a mental health need.

CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

On the day of the inspection 22 people were being provided with personal care by the service. □

The service is also registered with the commission to provide care to people housed under supported living arrangements. However, at the time of the inspection, the agency was not supporting anyone under this arrangement so we did not inspect this part of the service.

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. The registered manager was also the provider of the service and was supported in the day to day

management of the service by another provider.

Notice of inspection: The inspection was unannounced as whistle-blowers had contacted us to raise concerns about records being falsified.

What we did: Before the inspection we reviewed the records held on the service. This included reviewing notifications. Notifications are specific events registered people have to tell us about by law.

The office visit was completed on 25 and 26 February 2019.
At this visit we spoke with:

- a director of the company
- eight staff

We also reviewed
- nine people's care records
- 12 personnel records
- training records for all staff
- audits and quality assurance reports
- policies and procedures.
- records of accidents, incidents and complaints
- staff rotas

Following the office visit, we made phone calls to
- seven people
- two relatives
- three staff members
- a social worker

We also visited two people and talked with two relatives during the course of these visits.

Following the office visit we continued to request training and recruitment records from the provider so we could be assured people were being supported by staff who were safe to provide care. These were provided.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

At our last inspection on 6 March 2018, this key question was rated "Requires Improvement". We found the provider had not always assured themselves new staff were suitable to work with vulnerable people. We also found staff were not following best practice when administering prescribed creams. At the time we found a breach of the regulation regarding safe care and treatment. At this inspection, we found the service had deteriorated.

Staffing and recruitment

- Staff had not been recruited safely.
- The provider had recently assured us staff only delivered care to people when they had a DBS (Disclosure and Barring Service) check and two satisfactory references.
- We found staff did not all have DBS checks, appropriate references, application forms, photo ID or a record of an interview on their file.
- Staff without correct recruitment checks had not always worked with staff who had been recruited safely, when providing care.
- Risk assessments had not completed for staff who had, or had declared, convictions on their DBS check.

The lack of appropriate recruitment checks placed people at risk of inappropriate care. This demonstrates a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were not always sufficient staff to attend to all people's calls. Staff told us, sometimes, due to the volume of people they had to visit, they could not always get to people on time. The management team regularly had to cover calls too.
- People told us about late calls, missed calls and not knowing what time staff would arrive. Comments included, "Late calls happen a lot. Sometimes so late that lunchtime runs into tea-time, with hardly any space between", "My only concern is they are not always on time and sometimes I don't get any breakfast until nearly mid-day" and "Sometimes if they have trouble with staffing I might not get my 7:30am visit until 11am or later and don't get my morning medicines till then."
- People told us they did not always know exactly what time staff would arrive and were not always informed if staff were going to be late. One relative explained, "We are expecting someone perhaps at 8.30am but sometimes they don't come till 9.30am as they give themselves 30 minute leeway either side of 9am. […] is sometimes a bit frustrated by then.
- Staff rotas did not detail what time people's visits were or how long staff should stay. People's records showed they did not always get the right number of calls each day or did not receive their calls at the right time each day.

The lack of sufficient staff numbers meant people were not getting the care they needed. This demonstrates a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□Most people told us they were happy with their allocated visit time and reported that staff stayed long enough. However, people also explained, "Of course, there can be a tiny element of stress when care are suddenly put on the carers list by a manager and the carer has a long day as a result" and "Sometimes there can be a knock-on effect for carers as the day goes on and then they just want to get done and get on home."
•□People told us the staff members tried to be flexible about call times. One person told us, "They are all very friendly and as good as gold when it comes to moving timings around or cancelling calls."
•□People and staff told us the same staff usually visited the same people each week. This helped ensure people's needs were known to staff.

Using medicines safely
•□People were not always supported safely with their medicines.
•□Staff who administered medicines to people, had not all received training.
•□Staff's competence to administer medicines had not been assessed.
•□Medicines administration records (MARs) were not all completed accurately.
•□People's care plans did not always accurately reflect the actual support they were receiving with their medicines.
•□When people required support from staff to re order or collect their medicines, this was not always done effectively. One person had run out of medicines on a bank holiday as staff had not ordered them to be collected before the bank holiday.

Medicines were not always managed appropriately which placed people at risk of not receiving their medicines safely. This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□Following the inspection, the provider sent us a training matrix which showed all staff had completed medicines training. However, this still did not show staff's competency had been assessed.

Learning lessons when things go wrong
•□Information was not used to help ensure lessons were learned to make sure things did not go wrong in the future.
•□One person's notes stated they had a bruise where they had been hurt by the hoist.
•□The provider told us they were not aware of the incident but that the person's home was very small and it was difficult to move the hoist. They had not sought further information or to retrain staff to help ensure this didn't happen again to the person.
•□A log was kept of calls staff reported had been missed. There had been nine missed calls from the beginning of February to the date of the start of the inspection, 25 February 2019.
•□ No action had been taken to ensure there were fewer missed calls in the future.

The provider had not taken action to mitigate risks from occurring again. This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
•□People had some risk assessments in place but these did not cover all the risks relating to people's needs.

•Some people were at risk of skin damage. Staff felt they would notice any changes to people's skin as they saw people frequently. However, they told us they had never had any training on what to look for or what action to take.

People needs were not fully assessed for risks which placed them at risk of unsafe care. 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
•Staff had not all completed safeguarding training but told us they would know how to report any concerns they had.
•People told us they felt staff kept them safe and were concerned about their safety at home. Comments included, "I couldn't allow them in if I didn't think it was safe for me", "They really care about my safety, I know that", "They are always telling me what I need to do to be as safe as possible. It seems to be their top concern." and "It's only been four weeks but they've already given me lots of leaflets and told me about things designed to help me keep safe in my home."
•People who sometimes experienced anxiety added that staff understood how to support them at these times. "The carers are always very aware of my different moods and anxieties which can change every day, or during the day. They know how to flex what they do for me to suit my mood."
•Staff ensured people were safe before leaving the house. One person told us, "The staff know exactly how to position me and how to keep me comfortable. They place my pendant where I can reach it if I'm not actually wearing it."

Preventing and controlling infection
•People and staff told us staff used protective equipment such as gloves and aprons when providing care.
•The provider's training matrix showed staff had completed infection control training.

Inadequate

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

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience
- Staff had not always received training required for their role.
- Seven staff members had not completed an induction or shadow shifts; despite the provider assuring us they had, prior to the inspection.
- Not all staff had completed manual handling training, or provided evidence they had previously completed the training. However, they had still been enabled to provide care to people who required support to move.
- One staff member told us they had been working for the provider for three years. There was no evidence they had received medicines or manual handling training despite supporting people with these needs.
- One of the providers, who regularly attended visits, had not completed manual handling training since 2013.
- The provider sent us a training matrix prior to the inspection. However, it had not included the staff who we found to have no training in place.
- Following the inspection concerns were raised with us about a staff member moving a person unsafely. We requested evidence the staff member had undergone manual handling training but were told this could not be provided.
- Staff had not received training relating to people's specific needs, such as Parkinson's, skin care or Dementia. One person told us, "Some are not so alert to how a person feels when they are bed-bound and unable to do things for themselves that everyone else takes for granted."
- Most people reported staff appeared competent, however relatives told us, "I wonder what training they do have, they don't always seem confident" and "One or two of them don't seem so sure."
- Staff told us they did not have regular team meetings or one to one supervisions. They explained this left little opportunity to receive feedback about their work, raise concerns or discuss people's support.
- The provider's training matrix showed only four staff members had completed food hygiene training.

People were placed at risk of unsafe care due to many staff not being trained appropriately. This demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- Following the inspection, the provider sent us an updated training matrix, stating all staff had been trained in medicines and manual handling.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

•□People's needs and choices had not always been assessed before staff delivered care to them.
•□The provider told us they had not had time to assess all people as they had been covering visits to people.

•□Staff told us this meant they often did not fully understand people's needs before visiting them.

The lack of fully completed assessments of people's needs meant they may not receive personalised care. This demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

•□However, people mostly reported that staff understood their needs and delivered care which reflected their choices.
•□Staff knew people's likes and dislikes.

Supporting people to eat and drink enough to maintain a balanced diet
•□People told us they were happy with the support staff gave them to prepare meals and drinks.
•□One person commented, "They make my breakfast, make sure I have coffee available, then leave my lunch ready. On Wednesdays, when they come for 3 hours, we discuss menus and they help me make soups and other meals to freeze for the week ahead. It's so good that I can actually cook something for my husband again, instead of depending on him for every main meal."

Staff working with other agencies to provide consistent, effective, timely care
•□A social care professional confirmed the management worked well with them, and referred any concerns to them appropriately.

Supporting people to live healthier lives, access healthcare services and support
•□People said they believed staff worked well with their GP and other professionals involved in their care.
•□Staff told us they were confident referring any concerns they had to the relevant professionals.

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.

•□We checked whether the service was working within the principles of the MCA. Staff told us people using the service could make their own decisions, so capacity assessments had not been required.
•□Staff told us they had received some training but did not feel confident about the principles of the MCA.
•□Most people told us staff checked with them before providing care.

We recommend the provider reviews staff knowledge of mental capacity.

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

RI: 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; respecting equality and diversity
•□Staff clearly cared about the people they provided care to and wanted the best outcomes for them. Comments included, "I absolutely love it", "I am so passionate about it", "I get really attached to the people. They have lived a life. I love listening. They have all these different stories" and "You've got to give them the best care we can, and I do".
•□People confirmed they found staff to be kind and caring. Comments included, "They always come in smiling in the morning, and I find their happiness infectious", "All of them are such nice, kind, genuine people. I can't fault them."
•□People told us they appreciated the little extra things staff did for them that made them feel special. For example, "The carers always check what I need each time, and they can do little extra things like help put washing on or the rubbish out if I ask them" and "Staff will go above and beyond doing things for me to help, like making up the bed or making me a sandwich."
•□People confirmed staff left things they needed at hand for them, left people's homes tidy, and asked people if they needed anything else before leaving.

Supporting people to express their views and be involved in making decisions about their care
•□People told us most staff listened to how they wanted their care delivered.
•□However, one person raised a concern with us that a staff member, in conjunction with staff at the office had ordered a new bed for them without consulting them. They raised their concerns with an occupational therapist as they felt unsafe in the new bed. The occupational therapist agreed and the beds had to be changed back. They told us this had caused them distress.
•□The service user guide shared with people stated that the registered manager was "in charge" of people's care. There was no indication that people would be empowered to be in charge of their own care and decisions.
•□Staff gave examples of how they communicated with people who could not share their views verbally.

We recommend the provider reviews how they enable people to express their views about their care.

Respecting and promoting people's privacy, dignity and independence
•□People told us they felt staff respected their privacy and dignity and helped maintain their independence. Comments included, "They always encourage me to do some things for myself so that I don't lose that ability."

Requires Improvement

Is the service responsive?

Our findings

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

RI: 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
•□People did not all have care plans in place to guide staff how they wanted their care delivered, even though they had been receiving the service for over one month.
•□One person's relative told us they did not always get their needs met and there was no care plan in place to tell staff what the person needed.
•□Staff told us when they first provided care to people, the provider gave them brief information via text or a phone call about the person's needs.
•□They told us they would not have read the care plan before meeting the person. Relatives told us staff often didn't look at the person's care plan and other records, until after they had provided care.
•□Care plans that were in place described people's needs and preferences as well as their religious and cultural needs. However, these were not always reflective of people's current needs.
•□There was no evidence people's information and communication needs had been assessed.

People's care had not been assessed to ensure personalised care was provided. This demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

•□One person's specific religious needs were described in detail in their care plan and was well known to staff.

Improving care quality in response to complaints or concerns
•□People told us they were not aware of a complaints policy but would contact the office or the providers if they wanted to complain.
•□Most people told us that when they had raised concerns they had been dealt with promptly.
•□There was no clear record of complaints raised. For example, one person had made a complaint. A staff member told us action had been taken as a result and the person was now happy with the service. However, there was no copy of it in the office and no evidence of a response.

We recommend the provider review how complaints are recorded and responded to.

Inadequate

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

Inadequate: 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.

At our last inspection on 6 March 2018, this key question was rated "Requires Improvement". We found concerns with staff practice, found during spot checks, had not been actioned or used to improve the service overall. The provider had not monitored work delegated to other staff members. Staff had not raised concerns about poor staff practice promptly. Action had not always been taken following feedback from people. We found a breach of the regulation regarding how the service was run. At this inspection, we found the service had deteriorated.

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

- People did not receive high quality, person centred care and support because the providers had not ensured people had care plans and risk assessments in place that reflected their needs.
- They had not ensured staff were recruited safely or received training to ensure they kept people safe and followed best practice.
- The providers were not open and appeared to be dishonest in respect of recruitment, training and which staff were providing care to people.
- Information provided prior to the inspection about recruitment and training did not reflect all of the information found during the inspection, or the information people and staff told us.
- The providers told us certain staff, who had not been recruited safely, but whose names were on the service's rotas, had not entered people's houses or provided care. People and staff told us this was not the case. One person told us about one member of staff, "When he first showed up he told me he was not really trained to be a carer."

The lack of proper oversight of people's care, their records and staff recruitment and training placed people at risk of inappropriate care. This demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- Some people told us they were happy with the service they received.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The providers did not understand all regulatory and legal requirements they had responsibility for.
- The providers had not ensured they stayed up to date with best practice and did not both have up to date training in place.
- When we raised concerns about the service with the providers, they both blamed a staff member in the

office for the concerns. However, they had not completed checks of the staff member's work. They had failed to understand their legal responsibilities.
•□The provider's policies were not all up to date. Most stated they required review in 2018, but this had not happened.
•□The providers had been completing visits to people to provide care, due to being short staffed and were aware that not everyone had care plans in place; however, they continued to accept new people to the service.
•□There was lack of robust quality assurance systems

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•□There were no clear processes or procedures for engaging people, the public or staff.
•□Some people told us they saw the providers regularly but only because they were covering visits to people.
•□Staff told us their concerns about how the service was run, for example about the time they had available to complete their calls, were not always listened to.
•□People had previously told the provider, via a questionnaire and via the previous inspection that they would like to know which staff to expect. This had still not been implemented.

We recommend the provider review how they engage people and staff in the service.

Continuous learning and improving care
•□The providers had not used information provided to them, to learn and improve the service. We found similar concerns at this inspection to the last inspection on 6 March 2018.
•□Staff told us the providers regularly provided care and this helped them understand what challenges staff faced.
•□Staff told us the providers sometimes completed spot checks of their work, however these had not been recorded. There was no evidence any improvements had been made as a result of these checks.
•□One of the providers, who completed spot checks on staff practice had not updated most of their training since 2014. They may not have been able to advise staff on best practice.

The provider had not ensured practices, policies and records ensured people were safe. This demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Working in partnership with others
•□A social care professional told us they were happy with the way the service worked with them.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Service users needs had not all been assessed or recorded.

The enforcement action we took:
Remove the location

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people received safe care and treatment.

The enforcement action we took:
Remove the location

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to monitor the quality of the service.

The enforcement action we took:
Remove the location

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not recruited staff safely.

The enforcement action we took:
Remove the location

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not always ensured there were sufficient numbers of qualified, competent, skilled

and experienced staff to meet people's needs.

The enforcement action we took:

Remove the location