Amy Adams Homecare UK Limited

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Inspection report

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 23 October 2017 and was announced. We gave the registered manager 48 hours to make sure someone was available in the office to meet with us as office staff sometimes provide personal care.

This was our first inspection of the service since it registered with the Care Quality Commission on 29 March 2016.

Amy Adams Homecare UK is a domiciliary care agency that provides personal care and support to people living in their own homes. Most people using the service were older people, there were also younger adults with physical disabilities. There were 20 people receiving services from Amy Adams Home Care at the time of our inspection. Most people using the service lived in the London Borough of Bromley.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The provider did not always properly assess risks relating to people's care, such as risks relating to medicines management or pressure ulcers, and put robust management plans in place for staff to follow in reducing the risks. The provider did not always manage people's medicines well. For example the provider did not ensure staff made records of medicine administration accurately.

The provider did not always recruit staff using robust procedures to check their suitability to care for people. For one person with a criminal record the provider had not carried out a risk assessment to identify and manage any risks the person posed to people. The provider had carried out risk assessments in relation to two other staff who had criminal records. The provider also did not explore gaps in staff employment history. The provider checked staff identification, health conditions and obtained references from former employers as part of checking their suitability.

The provider did not always provider care in line with the Mental Capacity Act (MCA) 2005. This was because the provider allowed a relative to consent to a person's care packages, despite the relative not having legal authority to do so. In addition the provider did not carry out mental capacity assessments when there was reason to believe a person may lack capacity to consent to their care. The provider did not provide training to staff to help them understand their responsibilities in relation to the MCA.

Staff did not always receive appropriate supervision to support them in their role. This was because the provider only supervised staff once after their first six weeks of employment and did not schedule any further supervisions to allow staff an opportunity to discuss the best ways to care for people, receive feedback on their role and review their training needs.

Some parts of people's care plans lacked detail to inform staff about the people they were caring for. For example, a person's care plan did not set out the communication difficulties a person experienced or the best ways for staff to communicate with them. In addition the registered manager often recorded people's medical conditions using complex medical language which staff may not understand as they themselves did not always understand these terms. Information about people's goals and how the service can help them achieve them was not always recorded.

The provider did not have effective systems in place to monitor, assess and improve the service. The provider had not identified the issues we found during our inspection and so had not made the necessary improvements to be compliant with the fundamental standards. Our findings indicated the registered manager did not have a full understanding of their role.

The provider did not always submit statutory notifications to CQC as required by law which meant they did not support us to carry out our role in monitoring services.

The provider involved people in developing and reviewing their care and had systems in place to gather their feedback about the service they received.

The provider deployed sufficient staff to care for people and the registered manager provided care to some people to ensure they did not miss visits.

People were safeguarded from abuse and neglect. Staff received training in safeguarding adults at risk to help them understood how to respond if they suspected people may be being abused to keep them safe.

Staff were supported with a suitable induction and annual appraisal. The training offered to staff was suitable although training in MCA was lacking.

People were supported in relation to eating and drinking and in relation to their healthcare needs when this was part of their agreed package of care.

Staff were kind and knew the people they were caring for. Staff supported people to maintain their privacy and dignity and treated people with respect. Staff supported people to maintain their independence when providing care.

People knew how to complain and believed the registered manager would investigate any concerns they raised properly. The complaints policy contained some inaccurate information which may mislead people, and the provider told us they would correct this.

We found breaches of the regulations relating to safe care and treatment, consent, staffing, good governance and notifications. You can see what action we have asked the provider to take to address these breaches at the back of this report.

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. The provider did not always assess and manage risk to people well.

The provider did not always manage people's medicines well.

Staff were not always recruited via robust checks to ensure they were suitable to work with people. There were enough staff deployed to care for people safely.

People were safeguarded from abuse.

Is the service effective?

Requires Improvement

The service was not always effective. The provider did not always provider care to people in line with the MCA and did not train staff in how to provider care in line with the MCA.

Staff did not always receive appropriate supervision to support them to carry out their role. However, staff received appropriate training.

People received the right support in relation to eating and drinking and their healthcare needs.

Is the service caring?

Good

The service was caring. People were positive about the staff who supported them.

Staff knew the people they were caring for and developed good relationships with them.

People received choice and were supported to maintain their independence.

Is the service responsive?

Good

The service was responsive. People were involved in planning and reviewing their care and care was responsive to people's needs.

The provider responded to complaints appropriately and had systems to gather feedback from people and relatives.

Is the service well-led?

Requires Improvement

The service was not always well-led. Suitable systems were not in place to monitor, assess and improve the quality of the service.

The provider involved people and staff in developing the service.

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Detailed findings

Background to this 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.

This was a comprehensive inspection. The inspection took place on 23 October 2017 and was announced. We gave the provider 48 hours' notice of the inspection to make sure someone was available in the office to meet with us. This inspection was carried out by an inspector.

Before our inspection we reviewed information we held about the service. This included responses to questionnaires we sent to people using the service, their relatives and staff and professionals to gather their views on the service. We received responses from four people who used the service, one staff member and two relatives or friends. We did not receive any response from professionals.

During the inspection we spoke with the registered manager who was also a director of the company, as well as the care coordinator. We looked at a range of records including three staff files, seven people's care plans, records relating to medicines management and other records relating to the management of the service.

After the inspection we spoke with two people using the service and two relatives via telephone. We also spoke with one staff member. We also contacted the safeguarding team of the local authority where the service primarily operated to check whether any allegations of abuse had been made regarding the service.

Requires Improvement

Is the service safe?

Our findings

People were at risk of avoidable harm because risks relating to their care were not always assessed well by the provider, with suitable management plans put in place to reduce the risks. The provider did not follow published good practice guidance to assess and manage people's risks. For some risks there was no evidence the provider had carried out any assessment. For example, some people were supported to transfer by staff with equipment but risk assessments and management plans were not always in place. For one person the provider had not carried any risk assessments. The registered manager told us this was because the person refused to participate in the assessment process. However, the provider had not used other information to begin the risk assessment process, including a report from social services which included known risks such as those relating to mobility, skin integrity and medicines. The provider also did not use information from the care workers who provided live-in care since the first week in October 2017 in developing risk assessments as this would not have required the person to contribute, given their refusal to do so.

For some identified risks the management plans lacked sufficient detail to guide staff on caring for people safely. For example, the provider had identified a person was at risk of pressure ulcers and falls, yet the risks assessments contained only a brief summary of the risks and the level of risk and likelihood were not recorded. The management plans consisted of a few short sentences and contained little detail about how staff would reduce the risks in accordance with best practice. For another person the guidance to staff in relation to a choking risk was for care workers to "support the chest when assisting [the person] to get up" which failed to address how staff should support the person to reduce choking risks nor how to respond appropriately if the person began to choke. When we raised these issues with the provider they told us they would review their risk assessment procedures as soon as possible.

People's medicines were not always managed via robust procedures to reduce the risk of errors. Some people were administered medicines by staff yet the provider had not assessed the risks relating to medicines for individuals. The provider also did not have any management plans in place as part of the risk assessment process. This meant the provider could not be sure they were managing people's medicine safely. Medicines records showed staff did not always use the key provided to reflect the reasons they had not administered medicines as agreed in the care plan. For example we saw many staff recording a slash when they did not administer medicines to people and the registered manager was unable to confirm what the slash indicated. Staff did not use the given codes to record the reason why medicines had not been given such as the person refusing or being ill. This meant the provider did not ensure accurate records were made relating to medicines to ensure a robust audit trail.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from being supported by unsuitable staff. This was because procedures the provider used to check staff suitability were not always robust. The provider did not always check gaps in the employment histories of applicants which meant they may not always identify poor employment

histories. The provider carried out criminal records checks on applicants. However, when criminal records were identified the provider had not always carried out a risk assessments as part of reducing risks to people. We reviewed three staff files and found that three staff had criminal records. The provider had carried out risk assessments for two of these staff and determined they were suitable to work with people as the nature of the incidents meant people were unlikely to be at risk. For the third staff member the registered manager was unable to tell us the any further details. This meant the provider did not always ensure staff were suitable to work with people through robust recruitment checks. Other checks of staff suitability were satisfactory, including obtaining references from former employers, checks of identification and right to work in the UK. The provider also interviewed staff as part of checking their suitability to care for people.

There were enough staff deployed to care for people. People told us they had not experienced any issues with missed calls and care workers usually arrived on time and stayed for the agreed length of time. The registered manager told us there were enough staff at present although they were continually recruiting as part of expanding the business. The registered manager and the field care coordinator carried out care themselves to ensure people always received care at the right times.

People were safeguarded from abuse and neglect. People told us they felt safe with the staff who supported them and they knew how to raise concerns if they ever did not. One person told us, "I'd go to [the registered manager] if I didn't feel safe." The provider trained staff in these topics to help their understanding of safeguarding people.

We did not review the action the provider took in response to accidents or incidents because the provider told us there had been no accidents or incidents reported since they began operating.

Requires Improvement

Is the service effective?

Our findings

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 were not always cared for by the provider in line with the MCA. We identified the provider had allowed a family member of a person receiving care to sign a form consenting to care for the person. However, the registered manager confirmed the family member had no legal authority to consent on behalf of the person, such as lasting power of attorney. This meant in this situation the provider should not have allowed the family member to sign the consent form on behalf of the person. Our discussions with the registered manager indicated the person may lack capacity to consent to their care. The registered manager was not aware of their responsibility to carry out mental capacity assessments when there was reason to believe people may lack capacity to consent to parts of their care. In addition, the registered manager was not aware of the process to ensure decisions were made in people's best interests when they were found to lack capacity. When we raised our concerns with the registered manager they told us they would review their processes to ensure they followed the MCA.

In addition, the provider did not train staff in the MCA. This meant the provider did not support staff to understand the role of the MCA in their work. The registered manager told us they would review the training programme to include training in the MCA for all staff and they would also ensure they received the relevant training to increase their understanding.

These issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported by staff who were frequently supervised in a two-way process which allowed the staff member to raise concerns, receive guidance, feedback on their performance and to review any training needs. The registered manager told us they provided staff with a two way supervision after their first six weeks of employment. After this point the provider did not provide any further supervision to staff besides an annual appraisal during which staff performance was reviewed and goals were set for the coming year. The registered manager told us they spoke with most staff daily as they transported some staff to the location where they provided care each morning and they called other staff often to check how they were. However, although this meant staff received some support from the registered manager, it confirmed staff received insufficient formal supervision. Records confirmed the provider carried out spot checks of staff performance every two months, but these were a one way process and did not take the place of two way supervision.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There is a separate process for services such as Amy Adams Home Care which support people in their own homes. The registered manager confirmed there we no people using the service who required their liberty to be deprived as part of keeping them safe. The registered manager said they would ensure they understood the relevant processes to deprive a person of their liberty lawfully so they would follow these if necessary in the future.

People were supported by staff who received induction, training, supervision and appraisal from the provider. New staff received a three day induction which covered the expectations of them in their role as well as training in topics including safeguarding adults at risk, medicines management and health and safety. The provider used an external provider to train staff in topics including moving and handling, first aid, person-centred care, human rights in care, diversity and equality and dignity and respect in the first three months of staff employment and training in core topics was repeated annually. The provider also offered staff training in end of life care with a local hospice. The provider ensured new staff shadowed more senior staff until they felt confident to provide care to people alone and kept clear records of this. New staff were not always supported to complete the Care Certificate. The Care Certificate is a national qualification developed to provide structured and consistent learning to ensure that care workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe, quality care and support. This meant staff may not be reaching the expected standards of care workers during their induction period. However, the provider encouraged staff to gain diplomas in health and social work, offering financial incentives for completing these. Several staff had enrolled on diplomas and the provider was supporting them to complete these.

People were received the right support in relation to eating and drinking and their healthcare needs. However, people's care plans did not indicate the food they liked and guide staff on preparing it. The lack of detail in people's care plans meant there was a risk new staff would not provide food according to people's preferences, particularly if people were unable to express this. One person's care plan indicated staff should bring the person a spoon with their meal instead of a knife and fork but the reasons for this were not included to make clear whether this was the persons choice or for some other reason. Staff supported people with their healthcare needs in relation to their agreed care. For example, staff supported people to attend appointments, such as with the GP, where this was part of the agreed plan of care.

Good

Is the service caring?

Our findings

People liked the staff who supported them and spoke positively about them. A person who received visits from two staff at each visit told us, "The staff laugh and joke and are really happy. There are no awkward silences." A relative told us, "Staff are caring, they are friendly." A second relative told us, "[The care worker] is extremely good."

People developed positive relationships with staff who had time to chat with them and get to know them. However, one relative commented that, while they thought the service was "satisfactory to good" overall, the service should focus on improving the way staff communicated with people. The provider told us they would gather more information from people as part of the pre-admission assessment process to help staff know more about people. People told us they usually received care from the same care workers which meant they had consistency of care and encouraged good relationships to form.

People were treated with dignity and respect by staff and staff also maintained their privacy. People told us the provider treated them with respect. One person told us, "They are very respectful. I couldn't fault them." Most people and relatives told us the provider called them to let them know if their care worker would be arriving late. However, one relative told us the provider did not always let them know if their care worker was running late and this made planning their morning difficult. People also told us staff were respectful while providing care to them and took care during personal care to ensure they closed curtains and doors. Staff also ensured people were not uncovered unnecessarily during personal care.

People were involved in decisions about their care. People told us how they made choices in their own care, such as choosing the clothes they would like to wear and what they would like to eat. People also told us they decided the time staff came to provide care to them. People were supported to maintain their independence. One person told us, "Staff come to help me out of bed, so that in itself helps me be independent."

Good

Is the service responsive?

Our findings

People received care which was responsive to their needs. For example, a person and a relative told us when they found a care worker was not suitable the registered manager promptly changed the care worker and provided them with a more suitable one. A second person told us, "[Care workers] are always willing, they fall over backwards to help you. They do anything you ask!" A third person told us, "I've been really, really pleased. It's been much better than my previous agency." The person explained how the agency provided consistency of care as they usually received care from the same care workers, which was positive for them.

People's care plans sometimes lacked sufficient detail go guide staff in caring for them. People's care plans included details of people's likes and dislikes and backgrounds. However, people's care plans did not always include details about what was important to them, their goals and how the provider could support them in relation to these. Care plans did not always contain information about people's communication needs to guide staff on the best ways to communicate with people. For example, one person's care plan indicated they had 'communication needs' but provided no further information on this. The registered manager told us they would improve people's care plans when we provided our feedback.

The provider listed people's medical conditions in their care plans for staff to be aware of. However, the provider did not always explain complex medical terms and our discussion with the registered manager showed they themselves did not always understand these terms. The registered manager did not always explain medical terms within care plans so staff would understand them or include details of signs and symptoms of these conditions to inform staff. The registered manager told us they would review this information to make it easier to understand.

People were involved in developing their care plans. One person told us, "My care plan was all agreed with me and [my family member]." People and their relatives told us they met with the provider before they began receiving care to discuss how they would like to receive their care. The provider then developed care plans based on this information, as well as information from professional reports such as those from social services. The provider told us one person refused to be involved in developing their care plan. Because of this the provider had not put a care plan in place and staff were following the care plan developed by social services instead. However, the registered manager was clear they were in the process of putting a care plan in place. The staff who worked with the person were developing their care plan and the provider showed us the detailed notes they had made which they told us they would use to develop the care plan as soon as possible. The provider obtained signatures from people to show they were involved in and agreed to their package of care.

People's care was reviewed by the provider to check it continued to meet their needs. One person told us, "I've had a review with [the registered manager] and [my relative]." The provider met with people and their relatives soon after they began receiving care to check their satisfaction in all areas. The provider kept clear records of people's feedback to ensure an audit trail and acted to make changes to improve people's care where necessary. The provider then reviewed people's care after six months, and then annually after this point unless their needs changed. The provider also sent questionnaires to people annually to gather their

feedback on the service and told us they took action when feedback indicated improvements were required.

Complaints were investigated and responded to appropriately. People told us they knew how to complain and felt the registered manager would take any complaints they made seriously. A relative commented that the registered manager had visited to apologise when they raised a concern with them and they had resolved the matter promptly. The provider told us they had received one complaint since they began providing care to people. Records showed the provider had investigated the compliant and liaised with social services as part of this. In addition the provider issued a letter of apology to the complainant where they recognised their service fell short.

The provider summarised the complaints policy in the 'service user handbook' people were provided with when they began using the service. However, the policy was misleading as it incorrectly indicated people should forward any complaints to CQC if the complainant was not happy with the response of the service. CQC does not investigate individual complaints and instead people should raise complaints with the Ombudsman if the service is unable to resolve them. In addition the complaints policy also referred people to a regulatory body which disbanded many years ago. When we discussed these issues with the registered manager they told us they confirmed they had not been aware of these errors and would update the complaints policy as soon as possible.

Requires Improvement

Is the service well-led?

Our findings

The provider had some quality assurance processes in place but these were not always comprehensive. For example, the provider reviewed people's care annually and carried out spot checks of staff performance every two months to check they were providing care to people in the best ways. The provider also gathered feedback from people via annual questionnaires. However, the provider did not have suitable processes to review risk assessments to check these were appropriate as part of keeping people safe. In addition the provider did not have processes in place to audit medicines management. The provider had not checked staff recruitment procedures were robust and had not audited staff files to ensure they contained all the required information. The provider did not check care was provided to people in line with the MCA. The lack of sufficient audits meant the provider had not identified or resolved the issues we found relating to risk assessments, medicines management, staff recruitment and the MCA. The provider did not have a system to monitor the times staff arrived and finished caring for people. The provider had not identified the concern one relative raised with us about staff lateness and the provider not letting them know in advance and so had made the necessary improvements in relation to this. These issues meant people were at risk due to poor governance processes.

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

The provider did not always send notifications about significant events to CQC as required by law. The registered manager told us of one allegation of abuse made against the provider which they did not notify us of.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People and relatives were positive about the registered manager. One person told us, "[The registered manager] is very, very enthusiastic." A relative said, "The manager is ok, there's always someone who answers the phone when I ring." The registered manager was also a director of this family-run company. The registered manager was most recently a field care supervisor with a homecare agency and prior to this was a senior care worker in a number of care settings. The registered manager told us they did not have experience of managing care services prior to forming this company. Although the registered manager had completed a diploma in leadership and management in health and social care, our findings indicated they did not have a clear understanding of their role and responsibilities and the service they provided to people required improvement to ensure they were meeting the fundamental standards.

The provider involved people in developing the service. For example, as one person had a strong dislike of certain colours, the provider involved them in choosing the colour of the staff uniform. The provider also involved staff in developing the service. The provider held staff meetings twice a year or more often if necessary.

The provider worked closely with staff which helped them to support staff and also monitor the staff culture.

The registered manager transported many staff to care for people each day and they used this as an opportunity to discuss any concerns with them and to gather their feedback informally.

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 provider did not always notify the Commission, without delay, of any allegation of abuse, or abuse of people using the service. Regulation 18(1)(2)(e)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not have suitable arrangements to ensure the service acted in accordance with the Mental Capacity Act 2005 when people lacked capacity to consent. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care and treatment was provided in a safe way for people by assessing the risks to the health and safety of people of receiving the care and doing all that is reasonably practicable to mitigate any such risks. Medicines were not always managed properly and safely. Regulation 12(1)(2)(a)(b)(g)

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not operating effectively to ensure the registered person was able to assess, monitor and improve the quality and safety of the services provided by the service. Regulation 17(1)(2)(a)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate supervision. Regulation 18(2)(a)