Abafields Home Care Services Ltd

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Abafields Homecare Service is a Domiciliary Care Agency (DCA) providing a service to older adults, some of whom may have dementia, with a varying level of personal care needs. Staff provided care to people living in their own homes. At the time of inspection, the service was supporting 21 people. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The current manager had not yet registered with CQC but had started the application process. They had only been in post for several weeks and had also been recruited by the provider to manager their residential setting. The manager advised at the start of the inspection they had raised concerns with the provider that the service had not been set up safely and it needed to be closed. This was because care was being provided to people without appropriate records being completed. These included risk assessments, medication administration records (MAR's), daily records and support plans. In addition, support plans had limited information and only provided a profile for each person.

Some people did not have a care file set up in their home, to guide staff on what support they needed. Two people and one staff reported that information was shared with staff by people and relatives on what support they needed. Accidents and incidents had not been logged appropriately and safeguarding systems were not in place.

Quality improvement systems were not in place and audits had not been completed in line with the providers policies. Policies were in place, but they had not always been followed and the providers procedures did not reflect the guidance they provided. The manager had identified a significant amount of systems that needed to be implemented; however, the time they were able to allocate improving the homecare service was limited by their role as manager of the providers residential home.

Staff had not been recruited safely, references were not always requested and there was no evidence of interviews being completed appropriately. A robust induction had not always been carried out by new starters and there were gaps in other recruitment records. Several staff had recently left after the manager readjusted salaries to reflect the amount of time a person had been supported, which had left the service short staffed. The manager stated the deputy manager and care co-ordinator positions, were roles the provider had agreed to recruit; however, at the time of inspection there were no candidates identified.

People were not supported to have maximum choice and control of their lives. However, staff supported them in the least restrictive way possible and in their best interests; the systems in the service did not support this practice. People felt well cared for by the care staff.

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

Rating at last inspection (and update)
This service was registered with CQC on 23 February 2020 and this was the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about people not receiving support as scheduled, medicines being unavailable and medication records not being in place. Further concerns were raised about care not being assessed appropriately and people not receiving important support they needed such as continence and dietary care. A decision was made for us to inspect and examine those risks.

We have found evidence the provider needs to make improvements. Please see all the sections of this full report.

The overall rating for the service has been assessed as inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Abafields Homecare Services on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to person centred care, need for consent and safe care and treatment. Further breaches were identified in receiving and acting on complaints, good governance, fit and proper persons and staffing at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections 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'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

Abafields Home Care Services Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (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 carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 12 April 2021 and ended on 23 April 2021. We visited the office location on 12 April 2021.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some

key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with two people and two relatives to better understand their experience of the care provided. We spoke with five members of staff including the provider, the manager and three care workers.

We reviewed a range of records. This included three people's care plans and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. Other records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

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 Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People's individual support needs had not been recorded and risks relating to people's care had not been assessed.
- Trends in risks associated with people's care, were not able to be identified as there were no records completed for accident, incidents or safeguarding concerns.
- The manager had identified the service was not working in a safe way and this put people using the service at risk of harm. The manager said, "I've told [the provider] we need to close this service down, nothing has been set up properly and I don't have the time to do what I know needs doing. It's not safe, for the staff either. I think it needs to close and be setup properly, with all the systems in place, in a few years."

We found no evidence that people been harmed however, systems were not in place to safely assess and records risks relating to people's care. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider contacted CQC to advise they were closing down the service. We closely monitored this and all packages of care were reviewed and appropriate service had been identified for people to move to. The provider has submitted a notification that states they wish to de-register the service.

Staffing and recruitment

- Staff were not recruited safely. We found significant gaps in four staff personnel files. Gaps in previous employment were not always explained and qualification dates and certificates were missing. References were often missing and on occasion references had been completed by friends of the candidate. No interview records were available and there was no proof of identity or address in some cases.
- The manager said they had looked at staff recruitment files and identified concerns about recruitment not being robust. The manager said, "There was just a pile of paperwork and I had to try and figure out which paperwork belonged to who. I have asked staff to complete the correct paperwork and this is ongoing."
- The manager said the service did not always have up to date details of staff driving licences and car insurance details but stated they were currently working on getting this information.

We found no evidence people had been harmed however, systems were either not in place or robust enough to demonstrate staff were recruited safely. This placed people at risk of harm. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found discrepancies in the staff rotas. There were a number of occasions when staff did not arrive at the person's home at the allocated time. We found some calls were scheduled back-to-back, leaving no allowance for travel time.

We would have recommended the provider ensure robust systems were in place so people received their support at the allocated time had they not decided to deregister and close down the service.

● All staff had a disclosure and barring service (DBS) check, which we were able to verify at the inspection.

Using medicines safely
● Medicines were not managed safely. Medication administration records (MARs) were not always in place and staff reported recording people's administered medicines on the back of unrelated records. People did not have medication care plans and archived records, relating to medicines showed significant gaps.
● MARs had not been requested through the pharmacy until recently and information had either been typed or written on to the MARs by the previous manager or care co-ordinator.
● People did not have any records of 'as required' medicines and risk assessments relating to the administration of people's medication had not been completed.
● The provider had not worked in accordance with its own 'medication policy'.

We found no evidence that people had been harmed however, systems were not in place to ensure the safe management of people's medicines. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People were not protected from the risk of infection. COVID-19 risk assessments were not in place for staff or people receiving support from the provider. No COVID-19 guidance had been sent to staff and there was no guidance in the office.
● The manager told us no spot checks on staff practice had been completed and there were no records of these being completed previously. Personal protective equipment (PPE) was delivered to staff's homes by two staff who collected it from the residential home.
● We looked at how the risk of infections had been managed. The manager said staff had not been doing any COVID-19 testing until recently. Staff now did a lateral flow test twice weekly in addition to a polymerase chain reaction test each week; a log of these tests was kept by the manager.

We found no evidence people had been harmed however, systems were not robust enough to demonstrate staff followed safe infection prevention and control practices. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The staff and manager had completed donning and doffing training for the use of PPE such as gloves, masks and aprons. We saw infection prevention and control (e-learning) had been completed.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse. Safeguarding systems had not been set up since the registration of the service and there were no logs for recording safeguarding concerns or any actions taken.

We would have recommended that the provider implement robust safeguarding systems had they not informed us they were deregistering and closing down the service.

● Staff had a good understanding of how to raise safeguarding concerns. One staff said, "If anyone was at risk or had been harmed, I'd raise it with the manager, the council or CQC."
● People felt safe with the staff providing their care. One person said, "I feel safe and really appreciate them. They're quite good, I feel safe now they come to help me out."

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- Initial assessments for people had not been carried out appropriately and people reported having to guide staff on the care and support they needed. One person said, "Things were a bit sticky initially. The [staff] they sent to help my husband didn't really know what to do with him." A staff member said, "I've seen some people's care plans, two or three. Initial assessments are nowhere near where they should be, there's nothing in them. A couple of people needed reassessing because it's ridiculous."
- Care plans had a section where reviews could be recorded with people likes, dislikes and wishes. However, when we asked the manager for evidence of these, they said, "On the electronic database it does show that reviews have been undertaken with dates, but these do not show wishes, choices, what the client's expectations are or outcomes. Also does not show who was involved in the reviews."

We found no evidence people had been harmed however, the provider had failed to ensure people were involved in assessments of their care. This meant that the provider had not promoted person centred care. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Systems were not in place to ensure staff had the relevant skills or experience. There were no records to demonstrate staff had completed an induction. The manager told us they had not seen any historical induction records since starting in post.
- There were no records which evidenced supervisions being carried out for staff. One staff said, "This is how it's been; I didn't have any training or induction, they just knew me through [staffs name]. I haven't had one supervision."

We found no evidence people had been harmed however, systems were not robust enough to demonstrate staff had received such appropriate support, supervision and appraisal to enable them to carry out their duties. This placed people at risk of harm. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We saw a spreadsheet of training staff had previously completed in 2020; this included safeguarding, moving and handling, infection control and medication.

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.

● Systems to demonstrate people had consented to receive care from the provider were not robust. The manager told us consent to care and treatment forms should be in the care files stored in people's own homes, however, when they had visited people, they found that some people did not have signed consent forms in place.
● The manager stated there were no records relating to the principled of MCA could be found. It was not possible to assess through people's records whether MCA assessments were needed.

We found no evidence people had been harmed however, systems were not robust enough to demonstrate people had consented their care. This placed people at risk of harm. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support
● People's needs relating to diet, accessing the community and living healthy lives had not been assessed or recorded in people's support plans. However, people reported they felt well supported by care staff once they had passed on to them what support they needed.
● One person said, "They do whatever I ask them to do for me and always ask if they can do any more before they go. They cook for me; I can cook but it wears me out for the next day if I do."
● Another person said, "The new manager has looked at [persons] care needs and matched [them] with a new care staff member who had exactly the right experience and manner to work well with them. [The manager] is much better."

We would have recommended the provider ensure robust assessments were carried out for people's diet and hydration needs had they not decided to deregister and close down the service.

Staff working with other agencies to provide consistent, effective, timely care
● We asked the manager to provide evidence of the provider working effectively with local partners. The manager stated that none could be found.

We would have recommended the provider develop links with other agencies and partners had they not decided to deregister and close down the service.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
- Reviews of people's care had not been carried out, which meant people and relatives had not been involved in review processes.
- The provider had not sought feedback from people in the form of annual reviews, care plan feedback or surveys.

We found no evidence people had been harmed however, the provider had failed to seek and act on feedback from people, to review and assess the quality of care packages. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
- People and relatives were complimentary about the care they received. One person said, "I have been using them for about three months now. They're very helpful and go beyond the call of duty. We have a laugh and a joke which is lovely."
- One relative said, "Normal life was impossible with COVID-19 and it's been very hard to cope. The new manager has evaluated her staff's strengths and experience to help particular needs in clients."
- One staff said, "I don't let the problems get in the way of what I'm there for and I make sure the clients get the care they need. It's not their fault, I'll sometimes work over to make sure they have everything they need."

Inadequate

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 inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs; 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

- People did not have care plans completed appropriately. We reviewed several care plans however important information, which would inform staff how to support people with their individual care and support needs was missing. Information about how to support people with their likes, dislikes, interest and hobbies was not recorded.
- Activity plans had not been completed. However, people reported staff had helped them access the community when appropriate and where people were unable to access the community, staff had undertaken tasks such as shopping.

We found no evidence people had been harmed however, the provider had failed to ensure people had detailed care and activity plans. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- People had not always had access to their care records and people, staff and the manager advised that up until recently, care records had not been present in people's homes.

We found no evidence people had been harmed however, the provider had failed to ensure that people had access to their own detailed care records. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- People's complaints were not recorded. We asked the provider if we could review their complaints log and any actions taken in response to complaints that had been raised. The manager said, "Complaints haven't been logged, there isn't a system set up yet. I've been asking people to email me with any concerns and going through them like that. I've tried to go back through old complaints but because they haven't been recorded properly, it's not been easy."

We found no evidence people had been harmed however, the provider had failed to ensure robust systems were in place to record and respond to people's complaints. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives felt comfortable in raising concerns with the manager. One person said, "I am confident to talk to [the manager] if I have any problems with their care."

End of life care and support

● At the time of inspection there were no people who were at the end stages of their life. The service had an end of life policy in place to follow and care plans allowed for assessments to be completed.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider did not operate efficient governance systems. Effective oversight and monitoring of the service had not been implemented and we found several breaches of regulations during this inspection. There was no regular programme of audits or evidence of audits being completed since the service was registered.
- The manager said they did not feel the organisation had been set up correctly and they did not have the appropriate level of management support in place, such as a deputy manager or care co-ordinator. This had impacted on their ability to maintain effective oversight of the service.
- The provider had not worked in accordance with its own quality assurance policy. We asked the director about why there had been no provider oversight. The director said, "I have been too trusting in believing the previous managers were doing what they should be doing. But I believe we have a very experienced manager now."

We found no evidence people had been harmed however, the provider had failed to assess, monitor and improve the quality and safety of the service. Auditing and governance systems were not robust. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- It was clear from our discussions with staff they had not felt comfortable in raising their concerns about the management of the service since its registration. One staff said, "There's no consistency at all, I wouldn't raise anything with [the provider], there's no point because your told one thing and what happens is completely different."
- Another staff member said "You can see clearly [the manager] is trying to pick up the pieces of a service that hadn't been managed or tracked. There's no point reporting anything because there's so much that needs doing and the manager knows."

We found no evidence people had been harmed however, the provider had failed to seek and act on feedback from relevant persons for the purposes of continually evaluating and improving services. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● The manager was aware of their regulatory requirements to notify CQC and other agencies when incidents occurred which affected the welfare of the people who used the service.

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

● The provider had not sought feedback from people in the form of surveys or questionnaires. This meant the provider had been unable to analyse things that worked well within the service and areas where improvements could be made.

● Team meetings had not been carried out and staff had not received supervisions. Surveys had not been completed to better understand staff's feedback on how improvements could be made.

● There was limited evidence of the provider working holistically with partners across health and social care. As stated throughout this report a significant amount of assessments, reviews and personal support plans had not been completed; this meant the views of other professionals had not been used to inform a multi-disciplinary approach to people's care.

We found no evidence people had been harmed however, the provider had failed to seek and act on feedback from relevant persons for the purposes of continually evaluating and improving services. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People reported the manager had begun to review care plans with them and had been in contact to address any immediate improvements that could be made. One person said, "Although, [person] needs a complete reassessment, [the manager] has been amazing, really helpful and has kept us up to date with happenings."