Amicus Homecare Limited

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Inspection report

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13 January 2023

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Amicus Homecare Ltd is a care at home service providing personal care to people. The service provides support to people in their own home. At the time of our inspection there were 41 people using the service.

Not everyone who used the service received personal care. 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
People thought they were supported by kind and caring staff. However, improvements were required in several areas across the service. This included, learning lessons and records in relation to medicine management.

The provider had recently introduced several digital systems. This had led to gaps in people's care records including a lack of assessing risks. Management systems were not embedded or effective to identify concerns found during the inspection. There were short falls in auditing, reporting and systems to protect people from abuse.

Small improvements were required with recruitment checks and staff supervisions. The systems to listen to staffs' views and those of people who use the service had not been utilised for over a year. Although, people and their relatives had met the registered manager and were positive about them.

Systems to stop infections spreading including the use of gloves, aprons and masks were in place. The management were proud they had avoided any large COVID-19 outbreaks during the pandemic. They were also positive they were trying to support the crisis in health care by increasing how many people could be supported.

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
The last rating for this service was good (published 20 July 2018).

Why we inspected
We received concerns in relation to the management of medicines, governance systems, knowledge of the management around health and social care and staffing issues. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on

the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to medicine records, management systems in the service, safe care and treatment and systems protecting people from potential abuse at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Amicus Homecare 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 Health and Social Care Act 2008.

Inspection team
This inspection was carried out by one inspector and a member of the medicine team on site. An Expert by Experience completed phone calls to people and their relatives. 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 houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small, and people are often out and we wanted to be sure there would be people at home to speak with us.

Inspection activity started on 10 January 2023 and ended on 16 January 2023. We visited the location's office on 10 and 13 January 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people and 6 relatives on the telephone. We spoke with 10 staff members either in person or on the telephone. This included two directors, the registered manager, office staff and care staff.

We looked at a range of records including care plans, medicine administration records, training information, policies and procedures, governance records and information the provider shared with us.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Systems were not in place to recognise all potential abuse. Two incidents which should have been safeguarded had not been recognised by the management. No alerts to the local authority safeguarding team or CQC had been made in line with legislation and their own policies. A further potential safeguarding had been sent to the local authority and not CQC. People were being placed at risk of abuse due to lack of external monitoring.
- 6 out of 13 staff had not received training in safeguarding and some had only read the company policy as their training. This placed people at risk of abuse going unrecognised and/or unreported.
- The management lacked up to date training in safeguarding and were unable to inform us of who takes the lead to investigate without prompting.

Systems had not been established people were being kept safe from potential abuse. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the inspection, all staff who had not completed safeguarding training were signed up immediately. Additionally, the management sourced an appropriate level of training for themselves.
- People and their relatives told us they were safe. Comments included, "I have always felt safe with them. If I ask them to do anything, they do it", "…The carers are good with her and always keep her safe" and, "Mum is very safe, and the agency are really approachable."
- Staff could tell us how they would recognise signs of potential abuse and who to report it to including external bodies.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- Risks were not assessed in line with current best practice, guidance and their own policies. People's care plans contained no risk assessments meaning staff could provide inconsistent and unsafe care. For example, nothing was in place around people's moving and handling needs. This included if specialist equipment was used such as a hoist and slings.
- Training was not provided in line with people's health needs to reduce the risk of harm. Although the registered manager inducted all new staff there was no guidance for staff to refer to. For example, no information about how to recognise a diabetic person's health was declining. Neither was there guidance for reducing risk of pressure ulcers forming.
- The registered manager informed us assessments were completed prior to starting to deliver a person's care. However, environmental risk assessments were not completed to ensure staff would be able to

support people safely in line with their needs.
● People who had changing needs were not having their care plans updated in a timely manner. For example, 1 person had fallen in December 2022 and no risk assessment or care plan had been updated in line with this new need. The registered manager informed us they had told staff working with them about it.
● People were placed at risk of infections spreading. No individual COVID-19 risk assessments had been completed during the pandemic unless the person was COVID-19 positive. This was not in line with government guidance. The registered manager informed us that precautions were taken during the pandemic.

People were placed at risk of harm because risks had not always been identified and ways to mitigate them found. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider demonstrated the number of risk assessments being written had increased including for environmental risks.
● Staff knew how to safely use personal protective equipment (PPE) and examples of them having access to it was seen. Comments from people and their relatives included, "[Staff] always wear gloves and aprons", "[Staff] wear PPE when necessary and dispose of it in the bin" and, "[Staff] wear gloves and aprons all of the time."
● The registered manager completed inductions and made sure staff were confident prior to leaving them to lone work. People and their relatives were not sure all staff had regular spot checks. Comments included, "I have always found [registered manager] to be friendly. She did the initial assessment and also calls us regularly" and, "[Registered manager] comes occasionally to check in. She is very good." Following the inspection, the provider shared examples of how they had checked staff quality and safety whilst delivering care.

Using medicines safely
● Medicines were not always managed safely. Staff recorded when they supported people with their medicines. However, medicines records did not meet best practice requirements as they did not contain details of individual medicines administered.
● Systems were not in place to ensure time specific and critical medicines were managed safely. No risk assessments were in place to demonstrate how this would be managed if visits were delayed.
● Audits had not been updated in line with a new electronic care plan system which included medicine administration charts. This meant there was a risk that mistakes, or errors would be missed.

Systems were not in place to ensure records around medicine administration kept people safe from harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Following the inspection, the provider informed us of actions they planned to take to comply with current guidance and later showed us how they had been implemented.
● People's needs regarding any medicines support was assessed and recorded in care plans and visit notes for staff, in a personalised way. There was guidance for staff on how and when to assist with medicines for each person, including creams and external products and medicines prescribed 'when required.'

Learning lessons when things go wrong
● Systems were not effective to learn lessons when things went wrong. At the time of the inspection the registered manager signposted us to paper copies of incidents. Whilst actions had been taken these were

not always recorded and most audits of monthly incidents were incomplete.
● A second group of electronic incidents were shared by one of the directors. The registered manager was unaware of this second group, so they had not been reviewed. This meant lessons were not being learnt from all accidents and incidents occurring at the service.
● Only a few of the audits had been completed meaning patterns could be missed. Additionally, those that had been completed had limited information about learning that had occurred. One of the directors told us they talked about accidents and incidents at management meetings.

Staffing and recruitment
● People were supported by enough staff to meet their needs and systems were in place to manage any lateness. Although, some people and relatives felt sometimes their care calls were too close together. Comments included, "There are enough staff, even with all of these winter bugs going around", "It has never felt like they are short staffed" and, "There are enough staff. There are three different ones that come."
● Staff knew who they could contact out of office hours and said the registered manager would always respond to them. However, staff did not feel they had opportunities to express their views about how shifts were scheduled.
● Systems were in place to safely recruit staff including from overseas. Values based interviews were held and checks were undertaken. However, not all recruitment included staff's full employment history. Following the inspection, the management shared they had rectified this situation.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems were not in place or effective to ensure people received high quality and safe care. Audits were inconsistently completed or did not exist. For example, audits for accidents and incidents contained months that were blank. The registered manager confirmed they had not been completed. Medicine audits had not been updated in line with new digital systems in place leading to a risk medicines were not managed and recorded safely.
- Concerns found during the inspection had not been identified by the provider or registered manager's systems. Examples included lack of risk assessments, missing information in recruitment and notifications not being sent in line with legislation.
- The directors and registered manager lacked knowledge on current legislations, guidance and standards. For example, they were not identifying when safeguarding needed to be raised with external bodies for oversight. Neither had they recognised care plans for people with specific health conditions lacked details in line with statutory guidance and evidence-based standards.
- Systems were not in place or effective to demonstrate the management where improving when required. For example, the same concerns were raised following annual surveys in 2020 and 2021 about them being designed more for care homes. Care records were not reflecting incidents that had occurred and no one was applying the learning to all people.
- The provider had a lack of external oversight to ensure high quality and safe care was being delivered. They had failed to identify multiple concerns found during the inspection. This had led to multiple breaches in regulation.
- The provider had not ensured there was a clear staff structure in place to support the registered manager. There was a reliance on the registered manager to complete all management tasks including care observations and staff training. Neither had they kept their website up to date with the current staff.
- The management and staff were not always following the provider's own policies and procedures to keep people safe and provide quality care. Examples were seen with infection risks not being managed for individual people. Neither had training for staff been devised and implemented in line with their policy.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The directors explained they had unsuccessfully recruited suitable staff to support the registered manager on multiple occasions. Additionally, they had made large investments into digital systems which once established should provide robust oversight. Following the inspection, the provider informed us that they had sourced external oversight which would commence four times a year.
● The management led by example in creating a caring culture within the organisation which was reflected. People and their relatives were complimentary about the staff they received support from. Comments included, "The management are very friendly", "…They treat my dad like a human being rather than a job they need to finish" and, "Both the carers that my dad has are excellent."

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
● One of the directors talked us through their understanding of the duty of candour. It was not fully in line with the current legislation. Following the inspection, they demonstrated they had started to update their knowledge and applied it to incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and their relatives felt involved in their care as the registered manager would speak with them directly. Comments included, [Registered manager] just comes around and we have a chat", "The communication with [registered manager] is brilliant. We have a constant email communication" and, "I have received calls from the manager."
● Systems were in place to seek feedback from people, their relatives and staff. These were usually conducted annually. However, the surveys for 2022 had not been sent out.
● Staff felt they were engaged and supported when they moved to this country. Groups of staff from the same country were either house sharing or lived near each other. They felt positive about this response because it showed respect for their cultural differences.

Working in partnership with others
● The management were working with other health and social care professionals. One of the directors shared work they had been undertaking with the local authority including helping to free up hospital beds. They explained by sourcing staff from other countries with the right values it was helping to do this.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring risks were managed and mitigated to keep people safe.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not in place to make sure people were safe from potential abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place or effective to ensure people received high quality and safe care.