Amber Valley Total Care Ltd

Amber Valley Total Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Amber Valley Total Care is a domiciliary care agency providing personal care to people in their own homes. The service supports younger and older people, including people with dementia. At the time of our inspection there were 52 people using the service.

People's experience of using this service and what we found
The governance of the service was not effective because systems were not in place to identify areas where improvements were needed. Audits were not always effective in identifying where actions needed to be taken. The provider was not sure about what incidents and events they were legally required to report to CQC in line with their regulatory requirements.

The culture of the service was not inclusive and empowering for all staff. Some staff felt unable to raise concerns due to the structure and dynamics in the management team.

Risks to people were not always assessed and plans to mitigate risk and guide staff on how to support people in relation to specific risks were not always in place.

Staff were not recruited safely; pre-employment checks were not completed thoroughly.

People were not always supported safely with their medicines because the recording of medicines were not in line with best practice guidance.
We could not be assured that people were supported to have maximum choice and control of their lives or that staff supported them in the least restrictive way possible and in their best interests; because the policies and systems were not in place to support this practise.

People felt they were safely supported by the care staff. The care staff had good awareness of abuse and neglect and knew how to report any safeguarding concerns. However, people were at increased risk of harm because staff were not safely recruited, risks were not adequately assessed, care plans were not always comprehensive and there were shortfalls in communication between the staff and management.

Care staff received appropriate training and were confident in supporting people with their care. They attended to people's needs in a timely manner and had enough time allocated to spend with people, and knew their needs well. People told us staff were caring and reliable.

People had the opportunity to provide feedback on the service. There was a complaints policy in place and formal complaints were investigated.

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 inadequate (published 1 April 2023) and there were breaches of regulations. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an announced comprehensive inspection of this service on 26 January 2023. Breaches of legal requirements were found. The provider was issued Warning Notices requesting to improve safety of care and treatment, recruitment processes and governance of the service.

We undertook this focused inspection to check they now met legal requirements. We planned to inspect the key questions of Safe and Well led, however we found there was a concern with people's mental capacity assessments, so we widened the scope of the inspection to also include the key questions of Effective.

This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led.
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 remained 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 Amber Valley Total Care on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, recruitment and governance 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 remains 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 time frame 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effcetive below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well-led findings below.

Amber Valley Total Care

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 2 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
Amber Valley Total Care 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
This inspection was announced.
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 21 November 2023 and ended on 24 November 2023. We visited the location's office on 21 November 2023.

What we did before the inspection

We used the 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 sought feedback from professionals who work with the service. We used all this information to plan our inspection.

Inadequate

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 inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● The provider took limited actions to assess, monitor or improve the safety of people who use the service. Some risks were not assessed, and some people's support plans did not provide clear guidance for staff on how to support people. Information about risks and safety were not always comprehensive or up to date. Safety concerns were not consistently identified or addressed quickly enough.
● One person's care plan stated they were at risk of choking, however there was no guidance in place for staff to inform them how to respond if this person exhibited symptoms of choking. This meant this person was at an increased risk of choking. Another person had skin damage, however there was no care plan or risk assessment to inform staff how to support this person reduce the skin damage, for example how to help them with repositioning. This meant this person was at risk of further skin damage.
● One person who lived with diabetes, had no guidance for staff about this condition in their care plan. This placed the person at increased risk of suffering from diabetes related issues.
● Staff used a communication portal to share concerns about people's health and wellbeing, such as weight loss or increased confusion, However, we saw no evidence that the provider took any actions to follow up on the concerns, nor updated the people's care plans with the new information.
● People's assessments were not carried out in accordance with the Mental Capacity Act 2005. There were not best interest decision in place for people who lacked the capacity to make decisions. .
● There was a lack of evidence to show the provider had processes in place to learn from events. For example, the issues identified at the previous inspection were still not addressed at this inspection.
● Medicines were not always managed safely, for example there was no guidance in place for people who were prescribed 'as and when required' medicines and staff did not record the dose administered. This meant people were at risk of receiving the wrong dosage of medication placing them at risk of ill health. People's care plans did not always specify who was responsible for ordering people's medicines. As a result, we identified occasions where people were left with no medication.

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 and was a continued breach of regulation 12 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection the provider did not have systems and processes in place to recruit staff safely. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.
Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

● Staff were not recruited safely because the provider did not follow safe recruitment procedures. They did not carry out DBS checks at the appropriate level for all staff. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. We found 8 recruitment files of staff employed at the service that did not include checks with the Barring Service. This meant people were at risk of receiving care from unsuitable staff.

This failure to have systems and processes in place to recruit staff safely is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● There were enough staff to meet people needs. In the event a call was missed, there was an extra staff member to carry out the care call.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse because some people were supported by staff who were not recruited safely.
● People's preferences in relation to equality and diversity were not always treated with respect. For example, we saw that one person requested to be supported by female staff only, but this was not recorded in their care plan. We saw that on one occasion this person's request was not accommodated.
● All staff completed safeguarding training and had awareness and understanding of abuse. The staff knew how to report safeguarding related concerns. All staff told us they would alert the manager if a person was at risk of harm.
● People told us they felt safe receiving support from the care staff. They felt comfortable raising concerns about their own safety. One relative told us, "[Relative] is perfectly safe with them (staff)"

Preventing and controlling infection
● Staff had access to, and followed, policies and procedures on infection control that met current and relevant national guidance.
● Staff told us and people confirmed that staff were using PPE effectively and safely.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA

The service did not always work within the principles of the MCA.
- People had mental capacity assessments but they were not completed in line with the Mental Capacity Act Code of Practice.
- The outcome of people's assessments was not clearly recorded in people's care plans.
- Where there were concerns about persons' mental capacity to make specific decisions, this was not clearly recorded in their care plans.
- Where the capacity to make decisions was questionable, provider did not involve appropriate professionals to support them with their assessment.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were assessed, however the assessments were not comprehensive and did not always provide guidance for staff on how to support people.
- For example, one person with skin damage had no specific information in their care plan for staff to be able to support them appropriately.
- Staff did not always implement evidence-based guidance, for example on medicines management.
- Information was not always complete about people's likes, dislikes and relevant social history. For example one person preferred to only be supported by female staff, however this was not recorded and not always accommodated.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support

● People's health, care and support needs were monitored, however did not consistently include information on specific health issues, this meant there was a risk that people's health could deteriorate.

● For example, care staff recorded one's person's rapid weight loss, however there was no evidence that any actions were taken to support the person.

● We saw evidence of referrals being made to other agencies to support people.

● For example, liaising with the social work and district nursing team. However, the involvement of other health professionals and their advice and input into people's care was not always documented.

● The provider supported people to go out. For example, one person was supported to visit their relative who lived in another town.

Staff support: induction, training, skills and experience

● Staff received supervisions and appraisals on regular basis. Some staff felt supervisions were helpful and a safe space to discuss any concerns. Others felt they were not well supported by the manager and did not feel comfortable raising issues.

● Staff received training to carry out their roles. We saw staff training record and staff told us thy had good training opportunities.

● People told us staff were competent in their roles. One person told us, "They're (care staff) so good, very professional".

● All staff received induction which consisted of mandatory training and opportunities to work along more experienced members of staff. All staff told us they felt confident working independently following the induction.

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.

At our last inspection we rated this key question inadequate. The rating for this key question has remained 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
At the last inspection the provider failed to ensure the quality, safety and leadership of the service. The provider also failed to understand their regulatory requirements. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Systems for identifying, capturing and managing organisational risks and issues were not effective. We found significant concerns that risks to people's health and wellbeing were not always assessed, recorded or mitigated appropriately. The provider's auditing processes were ineffective and did not identify any of the shortfalls found during our inspection. For example, care plan audits did not identify the lack of information recorded in 9 different care plans we reviewed. This placed people at risk of unsafe care and treatment.
- Communication systems were not always effective. We saw a communication portal where staff could share any new information about people. There was no evidence of what actions were taken following the receipt of staff messages. For example, we saw messages from staff about a person becoming increasingly confused but there was no evidence actions were taken in response to the updates from the care staff. This increased the risk of important information about people's health and wellbeing being missed or not acted upon.
- The provider did not assess and record people's mental capacity to make decisions in line with the requirements of the Mental Capacity Act 2005. For example, we saw three care plans of people where the mental capacity was not accurately assessed or recorded. This mean that people were at risk of not being protected and empowered to make their own decisions about their care and treatment.
- The provider did not effectively audit recruitment checks and as a result 8 staff members were working without being checked against the barred list. This meant that service users were at risk of being cared for by staff who were not suitable for the role.
- The provider did not have a good understanding of what events they had notify CQC about. For example, the provider did not know they needed to notify us about a development of a pressure sore of grade 3 or above that develops after the person had started to use the service.
- The provider failed to effectively monitor progress against plans to improve the quality and safety of services and take appropriate action without delay where progress was not achieved as expected. Following our previous inspection which identified breaches of regulations, the provider had not made enough improvement to address any of those breaches.

The provider failed to ensure the quality, safety and leadership of the service. The provider also failed to understand their regulatory requirements. This was a continued breach of regulation 17 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The leadership of the service was inconsistent, and the provider's quality assurance systems were often ineffective in identifying shortfalls.
- We received mixed feedback from staff about the leadership. Whilst some staff felt happy working at Amber Valley Total Care, others did not feel listened to, respected, valued or supported. One staff member said, "The [registered] manager is rough with us. The management style is very outdated, they don't listen to staff". Another staff said, "(The registered manager) can be rude to the carers. [The registered manager] is never there. You don't really see [the registered manager] there (in the office) often."
- The culture of the service was not always transparent, some staff told us they did not always feel engaged or empowered to discuss concerns. "There are some carers who are related but you cannot complain about them to the managers".
- The provider regularly sought feedback from people using the service, for example by completing 'Quality Assurance Forms'. The feedback was analysed by the management team and we saw the general feedback was that people were happy with their care.
- People we spoke with as part of our inspection were happy with the care received and spoke highly of the care staff who look after them. However, they had little or no interaction with the manager. One person said, "No contact (with the manager) the only people we see are the carers themselves." Another person said, "Not much (contact with the manager), sometimes they won't even answer the phone."

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

- There has been no notifiable safety incident where the duty of candour applies since the last inspection. When incidents occurred, the provider investigated them in a transparent way and shared conclusions with the relevant people.

Working in partnership with others

- The provider worked with other healthcare professionals, for example we saw referrals to the district nursing team in relation to people's skin. We received positive feedback from the district nursing team about the care received by people.

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 12 HSCA RA Regulations 2014 Safe care and treatment The proivder failed to ensure risks to service users' health, safety and welfare had been adequately assessed and you did not do all that is reasonably practicable to mitigate the risks. Risk assessments were either not in place or did not provide enough information for staff on how to mitigate risks. Relevant health and safety concerns were not always included in people's care and treatment plans Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment, 12 (1)(2)

The enforcement action we took:

We imposed conditions on the registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The proivder failed to ensure risks to service users' health, safety and welfare had been adequately assessed and you did not do all that is reasonably practicable to mitigate the risks. Risk assessments were either not in place or did not provide enough information for staff on how to mitigate risks. Relevant health and safety concerns were not always included in people's care and treatment plans Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment, 12 (1)(2)

The enforcement action we took:

We imposed conditions on the registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to recruit staff safely.

The enforcement action we took:

We served a Warning Notice