24/7 Flex Care Ltd

24/7 Flex Care Ltd

Inspection report

Unit 21 Matrix House
7 Constitution Hill
Leicester
LE1 1PL

Tel: 07796008201

Date of inspection visit:
22 February 2022

Date of publication:
25 April 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
24/7 Flex Care Ltd is a domiciliary care agency providing personal care to people living in their own homes. At the time of the inspection 22 people were using the service.

People's experience of using this service and what we found

The provider failed to ensure safe recruitment checks were carried out and available for staff who worked in the service. Risks related to COVID-19 had not always been reduced through staff testing. Medicines records did not contain directives to enable staff to administer medicines safely. Measures had not always been sought to reduce the risk of potential harm to people from known risks. Risks assessments relating to people's care did not always detail how staff could keep people safe.

The provider failed to implement a robust and effective auditing system to monitoring people's safety and quality of care. The provider lacked oversight of staff employed in the service, people using the service and concerns we identified during the inspection which related to medicines, care call scheduling and COVID-19 testing for staff. Audits which had been completed were not successful at identifying shortfalls in practice and feedback sought from people was not always acted on to improve the service. We received conflicting information regarding the management of the service.

People did not always receive their full care call time which was allocated to them once their care and support needs had been assessed. Staff training records were inconsistent, and some training information was not available for some staff. The provider failed to demonstrate how people's mental capacity had formally been assessed relating to decisions about their care. Whilst some care plans contained minimal information, others contained details of external professionals who support people with specialist conditions or equipment.

People did not always feel involved with planning their care calls. Care call schedules were not planned to ensure staff had enough travel time between calls. The provider had received no formal complaints and most people felt they could raise a concern if required. People's communication preferences were recorded in their care plan.

Most people felt they were supported by staff who knew them well. However, there were occasions where people felt rushed during their care call and staff appeared disengaged.

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

Rating at last inspection
This service was registered with us on 24 September 2020 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about proper fitness of managers and recruitment of staff. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Responsive and Well-led sections of this full report.

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

Enforcement and Recommendations
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 and will take further action if needed.

We have identified breaches in relation to medicines, risk management, COVID-19 testing, recruitment of staff, and governance and oversight.

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
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always effective.

Details are in our findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our findings below.

Inadequate

24/7 Flex Care 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
The inspection team was made up of two inspectors.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Inspection activity started on 08 February 2022 and ended on 25 February 2022 We visited the location's office on 22 February 2022.

What we did before 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 requested some information from the provider about the running of the service. We used all this information to plan our inspection.

During the inspection
We spoke with three people and two relatives about their experience of using the service. We spoke with

seven staff which included, the registered manager, the office administrator and care workers. We reviewed four people's medicine records, three people's care records and a variety of information about the running of the service.

After the inspection
We continued to seek clarity on care call scheduling, staff employed at the service and people using the service.

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 of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment; Learning lessons when things go wrong

- The registered manager did not have an established system in place to ensure safe recruitment procedures were followed for staff employed by the service.
- Inconsistent information about staff employed during the inspection was identified. We were given conflicting information about which staff were due to start work and staff who were attending care calls in people's homes. This meant we were not assured there was enough staff to meet people's needs and they were being deployed effectively.
- The provider had failed to ensure all staff had appropriate pre-employment checks prior to attending care calls in people's homes. During the inspection, the registered manager was unable to produce five staff files, which included any reference of character or a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. This meant people were at risk of receiving care and support from staff who were not suitable to work with vulnerable people.
- Following the inspection, the provider continued to fail to produce documents relating to staff recruitment within set timescales.

Systems and processes to safeguard people from the risk of abuse;

- The provider had failed to ensure people were protected from the risk of financial and material abuse. Risk assessments had not been implemented in a timely way or followed to ensure measures were in place to protect people from known risks of potential harm.

The provider failed to have an established recruitment system in place and was unable to demonstrate that safe recruitment checks had been sought for all staff, this meant the provider was in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19 – Fit and proper persons.

Preventing and controlling infection

- The provider had failed to ensure people were at a reduced risk of the transmission of COVID-19. The provider did not have knowledge of the national guidance available relating to staff testing for COVID-19 and had no oversight of this. The provider was unable to assure us staff providing care to people, on the day of inspection, were negative for COVID-19. This meant people were at increased risk of the transmission of COVID-19.
- The registered manager failed to ensure staff carried out COVID-19 testing in line with the most up to date guidance. The service had no Lateral Flow Device (LFD) tests available for staff to use. There was no evidence or information to indicate staff completed LFD tests at the beginning of their working day, in line with national guidance.

● Some people told us staff did not always wear Personal Protective Equipment (PPE), which included a mask. This added a further risk of the infection spreading to people who received care and support.

Using medicines safely

● Medicines were not managed safely. The provider failed to demonstrate knowledge about 'prompting' people with their medicines and 'administering' them and gave conflicting information about the levels of support people required.

● People's Medicine Administration Record (MAR) charts did not detail the person's prescribed medicines, doses, frequency and route. Instead, it was recorded as 'blister pack'. This meant, there was no oversight regarding what actual medicines had been administered to people. Some people had their prescribed medicines listed in their care plans, but others did not.

● People's care plans did not consistently reflect the medicine they were prescribed. For example, one person told us staff supported them to take an inhaler. However, this was not recorded in the persons care plan. This meant there was a risk that the person could receive inconsistent support with the administration of their inhaler.

● Staff administering medicine were not always being assessed as competent in line with provider's policy. There was no evidence to show this being carried out for all staff who administered medicines and the registered person could not provide this despite it being requested. This meant people were receiving support with medicines by staff who may be unsafe to administer them. This placed people at an increased risk of harm.

Assessing risk, safety monitoring and management

● Risks associated with people's care and support were not always identified and measures were not recorded clearly on how staff could consistently reduce the risk of harm to them.

● One person was diagnosed with a progressive respiratory disease. However, there was minimal information in their care plan on how staff could identify when potential medical intervention would be required and how this was managed on a day to day basis. This placed the person at risk of not having safe support relating to their health condition.

● Some people were at risk of falls. Risks assessment in place lacked information how staff could reduce the risk of the person falling during and in between care calls.

● Records of care calls delivered to people showed staff did not always stay for the whole duration of the scheduled call. On occasions, some calls were reduced by up to 20 minutes. One person told us, 'I feel rushed and uncomfortable. They [staff] can be late and don't stay the time they should.' This meant people were at risk of not receiving safe care and not receiving the full care and time that has been commissioned.

Due to the provider failing to ensure measures were in place to protect people from known harm, staff not testing for COVID-19, medicines not being managed safely and risks associated with people's care not being clearly identified with detailed information on how staff could keep them safe, this meant the provider was in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 – Safe Care and Treatment.

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.

This is the first inspection for this newly registered service. This key question has been rated 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 Registered Manager told us some people who used the service lacked mental capacity and could identify them by name. However, the provider was unable to demonstrate how people's capacity had been formally assessed and there were no records indicating best interest decisions had been made in people's care plans.

The provider failed to ensure people's mental capacity had been assessed and best interest meetings were in place. This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11 - Need for Consent.

Staff support: induction, training, skills and experience
● Inconsistent information was identified during the inspection. Therefore, we were not assured training records were up to date and accurate.
● Training records showed The Care Certificate should be completed for all staff. However, we were unable to find evidence of this in staff files. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● Some staff files we were able to locate contained training certificates they had completed.

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

● People did not always receive the duration of care calls they had been assessed to receive. In February 2022, there were at least 14 occasions where a person had their care call reduced by 10 minutes or more. This meant, we could not be assured people were receiving care to meet their needs.

● Whilst some people had limited information in their care plan, most care plans contained routine information to provide guidance to staff on how to support the person during their care call at different times of the day.

● There was mixed feedback from people to whether their needs were met.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported with meals where this was appropriate to them and we found evidence of this in people's care notes.

● In people's care plans, their planned routine was recorded which included the direction of staff supporting people with meals and drinks.

● We received mixed feedback about staff assisting people with their meals. Whilst most people told us they had no concerns about this, some people told us staff were in a rush which sometimes meant their cooked meal was cold.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Whilst some care plans in place had minimal information, others had information where some people required medical intention and support. For example, one person had a catheter. Information about who to contact if there was an adverse event was available to staff, which meant it could be dealt with in a timely way.

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 require improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- We received mixed feedback from people regarding their dignity and independence.
- One person described an occasion where a member of staff left them unattended whilst they had no clothes on to take a personal call in the kitchen, which made them upset. During the call, the member of staff was not speaking a language the person understood. The person commented, "I was cold and [name of staff] called me rude when I asked for them to help me. They told me they thought I could do it myself."
- Another person said, "I have good upper body strength, so I can do certain things for myself. The carers help me where I need it."

Ensuring people are well treated and supported; respecting equality and diversity

- Most people told us they felt they were supported by staff who knew them well. However, there were occasions where people did not speak positively regarding their care.
- One person told us, "I feel like I am on high alert all the time, asking the carers; have you done this? Have you done that? One day I asked the carer to bring me some shower gel in so I could have a wash. The carer brought the water with no shower gel in it, but they brought a big green bottle of disinfectant."
- Some people and their relatives spoke highly about the staff and the care they received. One person told us, "I have a really good relationship with the carer. They never rush and they are really lovely." A relative commented, "They are very kind to [name of service user]."

Supporting people to express their views and be involved in making decisions about their care

- Some people told us they didn't always get their care call at a time that suits them, and the management of the service change the time without asking them. However, others were happy to have their care call at anytime.
- People told us they were able to feedback to the service regarding their care. One relative commented, "They [staff in the service] are really approachable. Really receptive to feedback". Another told us, "The company are good a responding if we want to make a change with [name of service users] call last minute."

Requires Improvement

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 requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The provider did not always schedule their staff deployment to provide person centred care.
- Some people told us their care calls were allocated for a time which did not suit them, and their call could be changed without their involvement. Some people told us they felt rushed during their care call and staff did not stay with them for the full duration of the scheduled call they had been assessed for.
- Records showed there were 18 occasions in February 2022 were staff were not allocated any travel time between calls. In addition, there were multiple occasions where staff were scheduled to be in two to three people's homes at once. This led to people's care calls being reduced in time and staff could be late.
- People's care plans were not always up to date with accurate information regarding their care. For example, the level of support people required with mobility, support with medicines and information associated with their diet. This could increase the risk of people receiving inconsistent care.

Improving care quality in response to complaints or concerns

- People told us they felt they could raise a concern with staff who work in the office. One person commented, "[Name of staff] is very approachable and reasonable." Another told us, "If I need anything or have anything to say, I just call [name of staff] in the office."
- We received conflicting information about who staff, and people thought the manager of the service was. Neither people or staff recognised the registered manager as the manager of the service and did not refer to them when talking about reporting concerns.
- The provider had received no formal complaints and had a policy in place to enable any formal complaints in a structured way.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The provider had recognised people using the service communicate in different ways and people's preferred communication was detailed in their care plan. This included hearing, vision and speech.
- Some people told us staff from the office had been to their home to talk through their care plan, so they knew what it contained because they were unable to read it.

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

- The registered manager did not provide us with any information which suggested there was people who used the service who received support relating to social isolation and supporting them to access the community or take part in activities.

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 failed to ensure they were clear about their role and responsibilities. The provider failed to ensure there was an effective and robust system in place to monitor the quality and safety of people's care. In addition, the provider failed to ensure people's records were kept accurate and fully reflective of who provided care and support to them.
- Systems and process were not in place to ensure oversight of the service. The provider was not clear on how many staff were working in the service and how many people were in receipt of care and support. In addition to this, the provider had not got a process in place to assure themselves staff were regularly testing for COVID-19 in line with the national guidance.
- Audits which were in place were ineffective at identifying shortfalls and were not meaningful. For example, the provider had completed an audit of people's call log notes. However, no information had been recorded about the purpose of the audit, any shortfalls or any action required to improve. Where medicine audits had been carried out, the provider had failed to identify missing signatures and the need for descriptive MAR charts.
- Records about staff and people using the service were not consistent. There were multiple discrepancies between staff who had signed the MAR chart and staff scheduled in to complete the care call. This meant, the provider did not have oversight about who was providing what care and support to people.
- There was lack of oversight over people's care calls and the provider failed to ensure a system was in place to monitor this. People consistently had their call time reduced, staff were scheduled in for more than one call at once and there was often no travel time between care calls. Electronic monitoring systems in place were not embedded and being used effectively by staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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;

- The provider had failed to act on feedback from people using the service. A survey for people had been carried out where three people had stated staff 'sometimes' stay with people for their allocated time. There was no information provided to us to indicate whether any action was taken following the receipt of this feedback.
- People and staff told us they were able to speak to the manager of the service if they had concerns. However, the manager they had referred to was not the registered manager and the provider told us this person was the office administrator. Therefore, open and inclusive communication regarding the

management in the service was not clear.
● The provider was unable to tell us the meaning of duty of candour. This meant we could not be assured if an event happens in the service, the duty of candour principles would be applied.

Due to the provider failing to ensure effective and robust quality monitoring systems were in place to ensure they had good oversight of the service, the provider was in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 – Good Governance.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others
● We received positive feedback about the culture of the service from relatives and they felt the staff were open and kept them well informed. One relative told us they received a copy of their call schedule, so they knew which staff where attending to their loved one. One person commented, "I can ring the office if I have any queries or concerns, they are reasonable and do listen."
● Staff felt supported by the management team at the service and one staff member referred to them as, 'kind, understanding and supportive.' One staff member told us, "I have stayed with this company because they really care."
● Staff worked with other partners to provide care and support to people. The service worked with local authorities and social workers.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure formal mental capacity assessments had been undertaken where there was reason to believe a person lacked mental capacity. In addition, there was no evidence of best interest decisions for receive care and support.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to associated with people's care had been consistently identified and thoroughly assessed, medicines were managed safely, in line with their own policy and failed to ensure staff were regularly testing for COVID-19.

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 provider failed to ensure people's Medicine Administration Records (MAR) were descriptive and contained full information relating to the medicines people were prescribed and staff were administering.

The enforcement action we took:

We imposed an urgent condition.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implemented and establish an effective and robust system to monitor and oversee the quality of people's care.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure measures were taken to reduce the risk of financial abuse to people, where there was a known risk relating to staff members.

The enforcement action we took:

We imposed an urgent condition.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure established recruitment procedures were in place to ensure staff were safe to work with people using the

service.

The enforcement action we took:

We served a warning notice.