Impact Healthcare Services Ltd

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Inspection report

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12 September 2022
14 September 2022
20 September 2022
17 October 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Impact Healthcare Services Ltd is a domiciliary care agency, providing care to people living in their own homes. At the time of inspection, the service was providing care to 20 people.

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
We could not be assured who was currently employed by the provider or what checks had been made before employing them. The risks associated with people's care were not always managed in a safe way. This included the provider not adhering to safe recruitment practices, not having up to date information about which staff were attending calls, poor management of medicines and risks associated with people's care not mitigated.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Although records showed staff had received training, this did not cover all the training required to meet the needs of people they were providing care for, or if all staff employed had received safeguarding training.

There was a lack of provider oversight of the service to ensure it was being managed safely and in line with current good practice. Quality systems had not identified concerns, errors and contradictory information in care and recruitment records. Audits taking place were not identifying the issues found during this inspection.

Throughout our inspection we received positive feedback from people, relatives and staff. However, the information about who these staff were from the provider was often contradictory, confusing and concerning.

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

Rating at last inspection.
The last rating for this service was good (published 22 December 2020).

At this inspection, we found the provider was in breach of regulations.

Why we inspected

The inspection was prompted in part due to concerns received about recruitment practices and management of people's care and visits. A decision was made for us to inspect and examine those risks.

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 recruitment practices, risk management, safeguarding people from potential abuse and governance.

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

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

Impact Healthcare 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 Health and Social Care Act 2008.

Inspection team
The inspection visit was carried out by 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.

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 48 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 7 September 2022 and ended on 17 October 2022. We visited the location's

office on 12 and 14 September 2022.

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. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service and three relatives about their experience of the care provided. We spoke with five members of staff including the registered manager.

We looked in detail at six care plans and care notes for 18 people, 10 staff recruitment files and the staff training matrix. We looked at a variety of records relating to the management of 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.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
• The provider had not carried out the required checks to ensure staff were suitable prior to them providing people's care. The provider's systems could not evidence what staff were visiting people and if they had been safely recruited.
• During the inspection the provider gave us three separate lists of staff names. These lists differed in the number of staff providing care to people and the names that appeared on these lists were different. For example, on the first staff list there were seven staff names, on the second list there were 11 staff names and on the third list there were 14 staff names. The information was confusing and contradictory and did not match staff names we found on people's care notes or information provided to us by people and their relatives.
• During the inspection the provider produced two separate and differing staff call rotas, for the same time period and again the information conflicted with staff names on people's care notes and what people and relatives told us.
• One staff member was not able to corroborate the information we were provided with in relation to their recruitment file. Other staff files we looked at did not always contain a full employment history, references were missing, and the references obtained had not been validated.
• We wrote to the provider requesting more information in relation to employment files. However, the information we received did not reassure us their recruitment processes were robust enough to ensure vulnerable people were sufficiently protected. Following the inspection, the provider told us they had stopped using staff where information relating to their employment could not be corroborated.

The registered provider had not completed the appropriate checks to ensure that staff were recruited safely into the service. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• People's risk assessments had either been completed incorrectly or lacked specific information to help determine an accurate level of risk. This meant staff did not always have access to the most accurate and up-to-date information regarding people's identified risks. This placed people at risk of avoidable harm.
• Two people had a pressure ulcer risk assessment (Waterlow) which scored possible risk of skin damage as 'at risk'. No information was found in relation to minimising the risk of pressure areas or damage to their skin integrity.
• One person was cared for in bed and had their continence products changed with support from staff. There was no information recorded on their mobility risk assessment about how to complete this safely.
• Care plans often contained conflicting information in relation to people's needs and risks. For example, in

one person's care plan it recorded they were cared for in bed but in another section, it recorded this person was able to get up and dress and use the toilet independently.
• One person's care plan recorded they had a ceiling hoist, a profiling bed and slide sheets. However, no guidance was provided to staff on how to use the equipment safely or the potential risks involved.

Using medicines safely
• We were not assured medicine practices were safe.
• During the inspection the provider told us three people were supported with medicines. We requested the medicine administration records three times during the inspection. Despite these requests these records were not provided.
• This meant we could not be assured the provider had suitable arrangements in place for the recording of medicines or to ensure service users received their medicines as prescribed.

We found no evidence that people had been harmed, however the provider had not ensured care and treatment was provided in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• We were not assured the provider's systems and processes were robust enough to ensure staff were deployed effectively to safeguard people or if these staff had all completed safeguarding training.
• Information provided in relation to people's scheduled care calls, differing staff contact lists and recruitment processes was confusing and conflicting which meant the information did not provide an accurate record of which staff members had delivered care to people.
• The provider told us three staff had recently left the service, the provider could not produce the recruitment files for these staff members so we were not assured they had the required checks or safeguarding training in place when they were working with vulnerable people.
• One staff member gave us a different date of birth to what was recorded on their criminal record check. This meant we could not be assured the check was accurate. The provider told us the staff member was no longer working at the service.

The provider had failed to ensure people were protected from potential abuse. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Some staff had received safeguarding training and understood how to recognise abuse and protect people from the risk of abuse. They were able to explain what actions to take if they felt people were at risk including to contact with outside organisations. A staff member told us, "I would report to my line manager any concerns or next senior person. If I was still unhappy, I would go to the registered manager. I would also contact social services or CQC."
• People said they felt safe and raised no concerns regarding fear of abuse. One person said, "I do feel safe when they are here." A relative told us, "I do not know what I would do without them."

• 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 found improvements were required to ensure the service was working within the principles of the MCA. The provider told us that people using the service had capacity. However, care plans were not clear about people's capacity and some care plans had been signed by people's relatives without recording a reason for this.

Preventing and controlling infection
• People told us staff wore personal protective equipment (PPE) when they delivered personal care to reduce the risk of spreading infections.
• Staff were provided with sufficient PPE and were aware of what they needed to do to prevent the spread of infections.

Learning lessons when things go wrong
• The provider told us no accidents or incidents had occurred at the service. A process was in place to analyse accidents and incidents if they did occur.

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 good. At this inspection the rating has changed to 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; 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; Continuous learning and improving care

- The quality assurance and governance arrangements in place were not effective in identifying shortfalls in the service. We could not be assured the provider had oversight or was able to drive improvements.
- We found shortfalls with safe recruitment practices, risk assessments and the systems in place to protect people from harm and abuse were not robust. There were shortfalls identified with staff training and medicines.
- Training information was disorganised and only included mandatory training. No specific training dependent on people's individual needs had been provided. For example, for people living with Parkinson's or in relation to pressure area care.
- The provider was not ensuring safe deployment of staff to meet people's needs safely. We found daily records of people's care and scheduling records were conflicting and confusing, and it was not clear what staff had been present during care calls.
- On the first schedule produced, the provider was recorded on the schedule as delivering care to people. This date corresponded with the provider being out of the country. Whilst an updated schedule was then produced this again demonstrated record keeping was disorganised and confusing.
- There was a lack of leadership and oversight at the service. We were not assured the registered provider who was also the registered manager was available and accessible to staff. Most staff referred to senior staff for their support and told us the provider was not always easy to contact.
- When we first contacted the service, we were informed the provider was out of the country and whilst the provider told us the reason for this, we were not assured suitable arrangements had been put in place in their absence.
- A contingency plan was provided following the inspection. However, it did not give us assurance that sufficient arrangements were in place when the provider was unavailable or out of the country. This document mentioned a Duty Manager being the person to contact, however during the inspection we were not made aware of this position or who held this position.
- The provider had not been able to produce all the documentation we had requested to demonstrate they were meeting regulatory requirements.

We found no evidence people had been harmed. However, systems and processes were not robust enough to demonstrate safety and quality were effectively managed. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• People and relatives were happy with the care provided, one person told us, "I am happy with everything and they have been much better than the last ones I had." A relative said, "I could not recommend this company highly enough and in particular [staff member] who looks out for me. It really provides me with back up."

• Staff told us regular staff meetings and supervision sessions were held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. A staff member told us, "[Senior staff member] ensures we are all okay." Another staff member said, "It is mainly because of carers that people are happy rather than the company."

Working in partnership with others

• Information demonstrated the service worked with others, for example, the Local Authority and healthcare professionals.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure people were protected from potential abuse. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 We found no evidence that people had been harmed, however the provider had not ensured care and treatment was provided in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Requirement

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found no evidence people had been harmed. However, systems and processes were not robust enough to demonstrate safety and quality were effectively managed. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had not completed the appropriate checks to ensure that staff were recruited safely into the service. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice