

Adopt Healthcare Ltd

Adopt Healthcare Ltd

Inspection report

480 Harehills Lane
Harehills
Leeds
LS9 6NG

Tel: 07856522354
Website: www.adopt-healthcare.co.uk

Date of inspection visit:
09 January 2024

Date of publication:
13 May 2024

Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service effective?

Inadequate ●

Is the service responsive?

Inadequate ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

About the service

Adopt Healthcare Ltd is a domiciliary care service that provides personal care and support for people in their own homes. At the time of the inspection the service was supporting 2 people with personal care.

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

Serious shortfalls were identified which impacted on the safety and quality of care people received.

Sufficient improvements had not been made to address the issues we raised at our last inspection. This included concerns in relation to the management of risk, medicines, staff recruitment, consent and good governance. We also identified people were not being protected from the risk of abuse.

The provider was kind, caring and knew people well. However, their oversight and management of the service was not safe or effective. The provider demonstrated a lack of understanding of many of the key principals required to ensure they delivered a good service. Their governance systems were not robust and had failed to identify the significant and widespread issues identified at this inspection.

People were not kept safe from the risk of harm. The provider did have robust processes in place to ensure lessons were learned when accidents and incidents occurred. Medicines were not managed safely.

Care plans and risk assessments did not contain the information staff needed to deliver safe, effective, and personalised care.

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.

We could not be assured people received effective nutritional support. There was no evidence of involvement from other health professionals involved in people's care.

Staff recruitment processes were not consistently safe. Staff received an induction and ongoing supervision and support from the provider. The ineffective monitoring of staff training meant it was difficult to confirm whether staff had received appropriate training.

People were supported by consistent staff who knew them well. People and their relatives told us overall they were happy with the care staff provided however some concerns were raised regarding how staff supported one person. We informed the local authority safeguarding team about this.

Staff followed good infection control practices.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

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 15 August 2023) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the improvements made were minimal and the provider remained in breach of regulations.

This service has been in Special Measures since 15 August 2023. The service continues to be rated inadequate overall. Therefore, this service remains in Special Measures.

Why we inspected

This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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.

Following our inspection, the provider sent us some additional information to demonstrate what actions they had taken to mitigate the risks to people. Our review of this information showed these improvements were still not effective in addressing the issues identified during this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'All inspection reports and timeline' link for Adopt Healthcare Ltd. on our website at www.cqc.org.uk.

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 remains inadequate. This is based on the findings at this inspection.

Enforcement

We have identified continued breaches in relation to safe care and treatment, staff recruitment, good governance and compliance with the Mental Capacity Act. We also identified a new breach in relation to safeguarding.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. 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 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 timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	Inadequate ●
Is the service effective? The service was not effective. Details are in our effective findings below.	Inadequate ●
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	Inadequate ●
Is the service well-led? The service was not well-led. Details are in our well-led section below.	Inadequate ●

Adopt Healthcare 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 was carried out by 1 inspector, a regulatory coordinator 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.

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. The registered manager was also the service provider and therefore in this report they are referred to as the provider.

Notice of inspection

We gave the service 24 hours' notice of the inspection. This was because the service is small and we wanted to be sure there would be someone available at the office.

Inspection activity started on 9 January 2024 and ended on 19 January 2024. We visited the location's office on 9 January 2024.

What we did before the inspection

We reviewed information we had received about the service and we sought feedback from the local authority. 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.

During the inspection

We spoke with 1 person who used the service and 1 relative about their experience of the care provided. We spoke with 2 staff members, including the registered manager and a care worker. We reviewed all documentation the provider had relating to the 2 people who were in receipt of personal cares. We looked at 3 staff files in relation to recruitment and staff supervision, and we also requested a variety of records relating to the management of the service, including policies and procedures and audits.

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. At this inspection 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: Learning lessons when things go wrong

At our last inspection systems were not in place to demonstrate risks to people's health and safety were managed effectively. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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

- People were exposed to the risk of harm. There was a continued failure to assess, monitor and mitigate risks in relation to people's health, safety, and well-being.
- Care plans and risk assessments had been developed but key information was missing and they lacked sufficient detail. For example, 1 person was at a high risk of falls and had recently sustained a serious injury following a fall. The person's falls risk assessment was not detailed and did not outline the specific actions staff should take to reduce the risks of future falls. The person had fallen 3 times in the last 4 months however their falls risk assessment had not been reviewed and updated following any of these falls. Staff and care records provided conflicting advice on what equipment should be used to safely assist the person to move. We were concerned this put the person at risk of further harm.
- Following our inspection the provider sent us updated care plans and risk assessments. These contained new risks which had not been previously identified and demonstrated the original documents were not fit for purpose. They also contained missing information and did not include a sufficient level of detail to ensure staff could care for people safely. This showed the provider lacked a thorough understanding of the principals of effective care planning and risk management.
- The provider did not have robust systems in place for learning lessons when things went wrong. The recording of accidents remained poor and did not include key information about further measures or actions the provider had taken to reduce the risk of recurrence. The provider completed an accident audit which included a review of the procedures in place however they did not complete a meaningful analysis of accidents to help them identify patterns or trends and enable them to reduce risks for people.

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 continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At the last inspection the provider had failed to ensure sufficient checks had been completed on staff, in line with their recruitment policy, prior to employment. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 17.

- The provider's recruitment processes were not consistently safe. Checks into staff's employment history were not being consistently completed. This meant the provider was not following their own recruitment policy to ensure sufficient checks had been completed on staff prior to their employment.

The provider had failed to ensure sufficient checks had been completed on staff, in line with their recruitment policy, prior to employment. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- The provider completed Disclosure and Barring Service (DBS) checks on staff prior to their employment. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- Staff had raised concerns with the provider that 2 carers were needed to safely move someone using the service. The provider was unable to provide evidence they had reviewed these concerns appropriately. No dependency assessment of the person's needs had been completed. We were therefore unable to establish how the provider had concluded they could be safely cared for by 1 staff member.
- People using the service told us the care staff provided was "acceptable" but said they did sometimes feel rushed when staff supported them. A relative told us, "I do feel that they are doing a good job."

Using medicines safely

At our last inspection medicines were not managed safely. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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

- Records were not consistently kept to show people received their medicines as prescribed. The provider told us one person took their own medicines and therefore staff did not need to complete any Medication Administration Records (MARs) for this person. However, information within daily notes and the medication risk assessment suggested the person now received prompting from staff to take their medicines safely. Therefore, MARs should have been kept in line with the provider's own medication policy and best practice guidance.
- Where MARs were completed, we saw these contained some errors and gaps in completion. This meant we were unable to establish people had consistently received their medicines as prescribed.
- Where there were risks associated with specific medicines there were no risk assessments in place to ensure these were effectively managed.
- We were not always able to establish people received their medicines in line with prescribers' instructions. For example, one person was prescribed a medicine which should have been given before food. There was no information to highlight this within the person's care records and it was not clear from the records kept

whether staff ensured this happened.

- Staff were not consistently completing records when they supported people with topical medicines such as creams.

People were placed at risk of harm by the failure to ensure the safe and proper management of medicines. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- People told us staff provided the support to take their medicines. One person told us, "No, I don't think they have ever forgotten our tablets, as far as I know." A relative told us the service could improve their communication with the pharmacy as they were often having to contact them on behalf of their family member to ensure they got the medicines they needed.

Systems and processes to safeguard people from the risk of abuse

- We were not assured the provider had systems in place which would protect people from the risk of abuse. The provider's safeguarding policy contained information which was not appropriate to the service. We saw two safeguarding incidents which had not been investigated or reported to either the local authority or CQC.
- One person raised a concern with us about how staff treated people using the service. They told us sometimes there were "altercations" where staff "argued" and "raised their voice." We made a safeguarding alert to the local authority about this.
- Staff had safeguarding training and were able to describe how they would identify and report abuse. Our discussions with the provider demonstrated they did not fully understand their role in investigating safeguarding incidents.

People using the service were not protected from abuse and improper treatment. This was a breach of Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

Preventing and controlling infection

- The provider had infection prevention and control procedures in place.
- Staff received training in infection control practices and had access to protective equipment (PPE). People told us staff used PPE effectively to help reduce the risk of infection.

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 inadequate. At this inspection the rating for this key question has remained inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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.

At our last inspection the provider failed to ensure consent to care was provided and documented and failed to follow principles of the Mental Capacity Act 2005. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 11.

- No formal capacity assessments were in place. Without capacity assessments staff could not be sure whether they would need to consider the MCA principles when undertaking care tasks.
- Staff told us one person may have lacked capacity due to cognitive impairment. The person had been asked to sign their care records the day before our site visit. The provider told us their GP had recently assessed them as having capacity. It was therefore not clear whether the person had capacity. The provider told us the person's next of kin had legal power of attorney for health decisions. However, without a formal capacity assessment it was not clear whether the power of attorney should be in force. Our discussions with the provider about this showed they did not have a clear understanding of the principles of the MCA.
- One person using the service had health conditions which could impair their ability to communicate. Care records identified these health conditions but did not contain communication strategies. This meant there was a risk staff would not have the appropriate information to ensure they could seek consent before proceeding with care.

The provider failed to ensure consent to care was provided and documented and failed to follow principles of the Mental Capacity Act 2005. This was a continued breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- We asked people using the service whether they felt able to make decisions about their care and if staff asked their consent before providing support and they told us, "It's not bad."

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

- People did not always have their needs appropriately assessed. One person had recently returned home after several weeks in hospital and a rehabilitation care service. Their care records had not been reviewed or updated since their return. We saw changes had occurred to their needs which had not been reflected in their care records.

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

- The provider was not taking appropriate actions to ensure people received effective nutritional support. We were told both people using the service had a reduced appetite and it could be a challenge to encourage them to eat. There was no clear information or strategies to assist staff with this, no risk assessments were in place and no formal monitoring of either person's food intake. The provider told us one person had been losing weight, however there was no recorded weight within their care records and no evidence of any referral or input by health professionals.
- People told us they received support to eat and drink. One relative told us, "They constantly ask if they want food or drink."

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

- We saw no evidence of effective partnership working with other professionals. No records of discussions with medical professionals were kept and there was no information from health professionals involved with people's care included in people's care plans.

Staff support: induction, training, skills and experience

- Staff received an induction before commencing work at the service. The provider told us staff received ongoing training in key areas. The monitoring systems in place for staff training needed improvement to demonstrate staff had received appropriate training.
- Staff received ongoing supervisions and records of these discussions were kept. Staff told us the provider was approachable.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate.

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People were not always receiving individualised care which met their needs, wishes and preferences. The provider had implemented care plans and risk assessments since our last inspection. However, they were not sufficiently detailed or personalised. For example, one person lived with dementia and could become anxious and agitated. There were no strategies in place to assist staff in calming and reassuring the person. Information from people using the service demonstrated staff were not always supporting this person appropriately. One person explained, "Sometimes they are a bit short with [them]."
- The provider told us they reviewed care records every quarter or when people's needs changed. However, we found care records had not been reviewed in a timely way or in response to key changes.
- No one was receiving end-of-life care at the time of the inspection. However, should people's needs change there was a risk not all staff would have the skills to deliver appropriate end-of-life care as the provider was the only staff member who had received training in end-of-life care.

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 did not always evidence how people's communication needs were being met. For example, one person had health conditions which could impact their ability to communicate and there was no communication plan in place.
- Our discussions with the provider showed they needed to refresh their understanding of the Accessible Information Standard.

Improving care quality in response to complaints or concerns

- The provider had a complaints procedure in place. No formal complaints had been received since our last inspection. We saw an informal concern had been raised and the provider had logged the concern, taken action to help improve the person's experience and responded to them to assure them the issue would not happen again.
- People told us they knew how to make a complaint. One relative told us, "I don't have any complaints and

haven't had to complain about anything."

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. At this inspection the rating remains 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; 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

At our last inspection systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17(1) of the Health and Social Care Act 2008(Regulated Activities Regulation) 2014.

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

- Significant shortfalls were identified at this inspection. We found breaches in relation to safe care and treatment, medicine management, consent, safeguarding, staff recruitment and good governance. The provider had not identified and addressed these issues as they did not have robust governance systems in place .
- The provider could not demonstrate continuous learning and improvement. Many shortfalls identified at the last inspection had not been addressed. The improvements they had implemented were basic and not always effective in identifying and addressing issues. The lack of effective monitoring of incidents and accidents risked the provider would not be able to fulfil their duty of candour requirements.
- The provider had implemented some audits since our last inspection. However, these audits did not have the risk level calculated and the provider was unable to explain the risk scoring system. Audits were not being completed in a timely manner. For example, checks of MARs had not been completed since August 2023. This meant any concerns or could not be promptly identified and addressed. We saw errors on MARs we reviewed which indicated more thorough auditing was required. Some key audits were also still not being recorded such as checks of daily notes. We found daily notes to be disorganised which meant they were difficult to review. We also saw evidence of incidents and changes to people's needs within daily notes which had not been identified and addressed by the provider due to the absence of audits.
- The provider was unable to provide some of the records requested during our inspection such as daily notes, MARs and staff rotas. Whilst some of these were provided following our site visit some gaps remained.

- The provider had developed an action plan following our last inspection. This had not been reviewed and updated since August 2023.

Systems to assess, monitor and improve the service were not sufficiently robust. Records regarding people's care and treatment were not accurate and complete. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008(Regulated Activities Regulation) 2014.

- The provider had displayed their rating from our last inspection in their office but it was not displayed on their website in line with regulatory requirements. They said they would ensure this was addressed as an immediate priority.

Working in partnership with others

- There was no evidence to show how staff worked in partnership with other health and social care professionals. For example, one person was receiving support from a physiotherapist. There was no advice or information from the physiotherapist reflected in the person's care records about how they should be safely supported to move.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristic; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People did not always have protected characteristics respected. Some staff did not provide appropriate support which respected people's differences. People's care records were not always up to date or person-centred. People told us the provider respected their relationships and recognised the importance of ensuring partners had time together. The provider told us people using the service were encouraged to participate in community activities for example, attending church.
- Staff told us they felt well supported and regular staff meetings were held.
- The provider was kind and caring and knew the people who used the service well. People told us they would respond positively to feedback from people about how their care and support was delivered or any improvements they felt were needed to the service.