

My Horizon Care Ltd

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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 caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

My Horizons Care Ltd is a domiciliary care service providing personal care to adults and children. At the time of the inspection it was providing care and support to 10 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

There was a lack of clear and accurate documentation relating to people's care and support, or the management of the service. This meant, in some areas, it was unclear how the service was operating. Records of care delivered were not completed in a consistent way, meaning it was difficult to establish the care and support provided.

Medicines were not managed in a safe way. Assessments of the support people needed with medicines were not carried out and records relating to the support provided were not always accurate or complete. Some risks to people's health and safety were assessed but this was not consistent, and in some areas, there was an absence of adequate risk assessments. Safe recruitment processes were not always followed, checks on new staff were not suitably robust and adequate records were not available. There were enough staff deployed to ensure people received a consistent service.

Staff received a range of training however no practical moving and handling training had been provided to staff. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. We saw evidence the service worked with other health professionals to co-ordinate people's care and support.

Staff were kind and caring and treated people well. People received care from familiar faces which helped ensure personalised care was provided.

Care plans and risk assessments were in place, although some of these needed more detail. No information on people's end of life arrangements were recorded. People said they felt able to complain and any minor issues or problems were dealt with by the registered manager.

Relatives said the service was personalised and met individual needs. Staff demonstrated they were committed to the people they supported. However, there was inadequate governance of the service, with the service failing to ensure compliance with regulatory requirements. Records were not available, were provided to us after significant delays and/or the quality and content of the records provided was not sufficient.

Relatives told us they were happy with the care and support provided by the service. They said care was person-centred and reflected individual needs. Relatives said staff were kind and caring and that a

consistent team of staff was provided.

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 19/06/2020 and this is the first inspection.

Why we inspected

The inspection was prompted in part due to concerns received about recruitment and training in addition to us not having inspected the service yet. A decision was made for us to inspect and examine those risks. We planned to undertake a focussed inspection of the safe and well led domains but during the inspection we identified a number of concerns relating to documentation, so we widened the scope of the inspection to become a comprehensive inspection

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led domains of this report. Whilst we did not identify any impact on people, there was the potential for people to come to harm, as risks were not adequately assessed and there was an absence of key documentation.

Enforcement

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 have identified breaches in relation to risk management, medicines management, record keeping, training and recruitment. 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 work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures

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 effective?

Requires Improvement 

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good 

The service was caring.

Details are within our caring findings below.

Is the service responsive?

Requires Improvement 

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate 

The service was not well-led.

Details are in our well-led findings below.

My Horizon 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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was carried out by one inspector.

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 registered manager 48 hours' notice of the start of the inspection. This was because we wanted to make arrangements to speak with people who used the service prior to visiting the office. In addition, it is a small service and we needed to arrange a suitable time for the registered manager to be present in the office to support the inspection.

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 authorities and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to

send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

The inspection took place between 9th February and 4th March 2021. We spoke with the relatives of five people who used the service about their experience of the care provided. We spoke with six members of staff including the registered manager and care workers. We reviewed a range of records both remotely and when we visited the office location on 1 March 2021. This included four people's care records and two people's medication records. We looked at staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who work with the service.

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

Assessing risk, safety monitoring and management

- Comprehensive risk assessments and care documentation was not always in place to demonstrate risks to people's health and safety had been fully assessed and mitigated. Moving and handling risk assessments did not fully assess the risk of using each piece of equipment and did not provide clear instructions on how to use equipment safely. In one person's records it was also unclear what equipment staff were using.
- Risks associated with behaviours that may challenge others and taking people out into the community were not adequately assessed and subsequently there was no clear plan for how to keep people safe when they displayed behaviours that may challenge others, or access the community with staff. The registered manager told us they would ensure these were developed
- Records of care delivered were not always accurate, complete or legible. This meant that in some circumstances we were unable to establish the full details of the care and support people were receiving. This also increased the risk to people because without accurate record keeping, people's safety could not be properly monitored by the service.

Risks were not always adequately assessed to ensure that people were kept safe when being supported by the staff team. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We did not identify any impact on people, although there was the potential for harm as robust risk assessments were not in place.

- Relatives told us that staff worked safely and competently and that because they received care from a consistent staff team staff got to know people and how care was supposed to be delivered. This helped mitigate some of the risks associated with poor documentation.
- Care documentation showed risks associated with people's living environments had been assessed. We saw evidence of action taken for example moving inappropriately stored medicines, to help keep people safe.

Staffing and recruitment

- Safe recruitment practices were not consistently followed. Up-to-date Disclosure and Barring Service Checks (DBS) had not always been obtained when staff started work. The registered manager was not fully aware of legal requirements in this area. Where staff worked with children, there was a lack of information on file about whether the children's barred list had been checked as part of the recruitment process.
- Whilst there was reference documentation detailing staff conduct in previous roles, the authenticity of these could not be verified as there was no proof a reference request had been made to staff's previous organisation. The registered manager told us some references had been taken over the phone, but this was not clear on the reference document. Some references did not contain the name or position of the person

giving the reference. Other inaccuracies and inconsistencies in recruitment documentation were found. For example one staff member's reference was dated prior to their application form and CV being received by the service and the registered manager could not adequately explain this.

- Where agency staff had been used there was no evidence these staff's credentials had been checked ahead of providing care and support to people. When we requested information about the checks undertaken on a staff member who the registered manager said was from an agency, inadequate information was provided.

There was a failure to ensure that the correct recruitment processes and checks were carried out for staff members working at the service. This was a breach of Regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not identify any impact on people, although there was the potential for people to experience harm if safe recruitment procedures were not followed.

- There were enough staff available to provide care and support. Relatives said staff were reliable and staff arrived on time. There was enough time on the rota for staff to deliver care in an unrushed way with a small number of visits each day.

Using medicines safely

- Medicines were not always managed in a safe way. For example, entries made on Medicines administration record (MAR) charts were not always consistent with the pair of staff who had signed the daily records of care which made it hard to establish who had provided medicine support on some days.
- People did not have a medicine assessment detailing the exact nature of the support they required with their medicines. One person was prescribed "as required" medicines but there were no protocols detailing how these would be given safely. Another person's records showed creams were being applied but their care plan said they were not prescribed creams and there were no further records of administration.

People's medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not identify any impact on people, although there was the potential for people to experience harm if safe and proper medicine processes were not followed.

- Staff providing medicine support had received medicines training and had their competency to give medicines assessed.

Preventing and controlling infection

- Overall, people and staff told us that staff wore appropriate Personal Protective Equipment (PPE) and maintained good hygiene. One relative said "they all wear masks, and put aprons/gloves on during personal care." Staff told us they had a plentiful supply of PPE. We saw they had received training in infection control and had an appropriate understanding of when to wear PPE.
- We asked the service whether they had a COVID-19 risk assessment in place and were provided with a risk assessment which although stated it was completed by the Registered Manager did not reflect the service provided. For example, it had the name of another company throughout and mentioned Supported Living services which the service did not provide. The risk assessment needs to be specific to the organisation and ways of working in line with government guidance. It was unclear what some of the specific measures were in place to help reduce the risk of COVID-19 particularly as the service operated in such a diverse way, providing care to older people in Somerset and North Yorkshire and children in Leeds.
- The registered manager was unclear what the testing regime was for staff and there were no clear records provided to demonstrate when staff had received COVID-19 tests.

Appropriate risk assessments relating to Infection control had not been implemented. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We did not identify any impact on people, although there was the potential for people to experience harm if a robust risk assessment relating to COVID-19 was not in place.

Systems and processes to safeguard people from the risk of abuse

- Some systems were in place to ensure people were protected from abuse or avoidable harm, although because of the issues with staff recruitment checks we did not feel completely assured about safeguarding. It was also not always clear from records who had provided care and support to people, this lack of information could hinder any safeguarding enquires.
- Relatives told us people were safe from abuse and avoidable harm. They all said they felt comfortable with the staff who provided care and support. Safeguarding and whistleblowing policies were in place which staff had signed to state they understood. Staff had also received training in safeguarding vulnerable adults and children.
- Whilst there had been no recent safeguarding incidents, we saw some minor concerns had been discussed appropriately with social care professionals.

Learning lessons when things go wrong

- We saw evidence some incidents had been appropriately recorded on an incident form and discussion had with health professionals. However, care plans had not been updated following these incidents with additional strategies to help guide staff.
- One incident response the registered manager provided to the local authority over the incident was not suitably robust, as it had failed to consider key information relating to the situation. We spoke with the registered manager about the need to ensure incident investigations were more thorough and robust.

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.

Staff support: induction, training, skills and experience

- Records showed staff had received a range of training on and after induction to the service. However, staff had not received any practical training or competency assessment in moving and handling, despite using a range of equipment such as slide sheets, stand aids and hoists. The registered manager told us this had not been possible because of the COVID-19 pandemic and was going to be arranged shortly. However, we would have expected alternative arrangements to be put in place examining staff competency. The service had access to a course in Mental Capacity Act (MCA) and we saw evidence one staff member had completed this, however because the training matrix and staff files we viewed did not contain details of this course we were unable to confirm whether all staff had received the training.

Staff had not received training necessary for their role. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We did not identify any impact on people but there was the potential if appropriate training was not provided.

- Relatives we spoke with told us staff had the right skills and knowledge to care for their relation. One relative said of Staff "All have the required basic understanding [of care needs] and some have better understanding, some of the staff are amazing." People received care from a small staff team which helped them build up the knowledge about people. Staff we spoke with were knowledgeable about people.

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

- Relatives and social care professionals told us that people receiving care and support were happy with the care provided and they had no concerns.
- People's basic care needs had been assessed although some care plans needed more detail to demonstrate a holistic assessment of people's needs had been carried out. The service needed to ensure it worked more closely to national guidance in areas such as COVID-19 and medicines management to promote safe and effective care.

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

- The service provided very minimal support with eating and drinking. However, we saw care plans contained clear information on the dietary needs of people and the role of the family and others in meeting their dietary and nutritional needs. Staff had received training in food hygiene and food safety.

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

healthier lives, access healthcare services and support

- Relatives we spoke with told us the service worked with others to meet healthcare needs. We saw evidence in care records of liaison with health professionals and the registered manager was able to give further examples of this. Basic information on people's healthcare needs and how to support them to stay healthy was present within care plans.

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 Act 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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The registered manager told us no Court of Protection orders were in place. We found they had an appropriate understanding of the MCA and consent processes. People's consent for care and support was obtained prior to care delivery and we felt assured appropriate processes would be followed where people lacked capacity to consent to this.

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 good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People were treated well and respected by staff. Relatives all said staff were kind and caring. One relative said, "[Staff] have been fantastic, [staff] do a really good job and are respectful." Another relative said "Staff are lovely and so is the manager, we have almost become friends, there is a lovely friendly atmosphere."
- Staff demonstrated they knew people well and had developed good relationships with them. A small number of staff visited each person which promoted the development of good relationships. People received care and a consistent time each day which showed respect towards them.
- Staff had received training in equality and diversity and policies were in place to ensure people's individual needs and requirements were catered for. Adjustments had been made to care and support arrangements to ensure people's individual needs were met.

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

- Relatives said they were involved in making decisions relating to their care. They felt communication was good and they were always consulted about any changes to care. We saw evidence in the care records that people and their relatives had been involved in the creation of care plans and people's likes and preferences were recorded. Relatives told us the registered manager often contacted them to check how things were going and they felt listened to. Where they had made suggestions, they said these had been actioned.

Respecting and promoting people's privacy, dignity and independence

- Relatives told us staff were respectful of their homes, and helped people maintain dignity and privacy. Staff had received training in person-centred care and were able to give examples of how they ensured dignity.
- We saw on a couple of occasions, people had been referred to as the incorrect gender or name in care documentation, we raised with this the registered manager to ensure it was addressed.
- Basic information was recorded within care plans about how independence was promoted, and relatives said the service got the balance right between offering support and independence.

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

- Relatives told us that care needs were met by the service and that appropriate care was consistently provided, although documentation was not always available to demonstrate care needs had been met. One relative said, "They do everything to a high standard." We saw evidence care was delivered by a small staff team. Where records were available, they showed that care staff arrived on time and this was confirmed by people they were supporting.
- Daily records of care were not always consistently completed, on some occasions it was unclear what times staff had attended calls and, in some cases, whether calls had taken place. The registered manager recognised there were problems with the recording of care delivery using both the electronic and paper recording system and assured us that improvements would be made.
- People's care needs were assessed, and care plans and risk assessments produced. These contained information to assist staff on what to do at each visit. However, some records needed further information recording. For example, one person's morning call did not detail about continence care, and where staff provided overnight support to another person there was a lack of information about what staff did during the night-time period.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The service was meeting the requirements of the AIS. Where documentation was available, it had been made available in formats appropriate for people and policies were in place to support compliance with the standard.

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 service provided social activity for a small number of care packages. A relative told us good support was provided in this area. We saw basic information was recorded within care records to assist staff, although more detail was required about how staff should provide this social support.

Improving care quality in response to complaints or concerns

- Relatives told us they were happy with the care and support provided by the organisation but where they had minor issues these had been sorted out appropriately by the registered manager.

End of life care and support

- Staff had received training in providing end of life support and we saw adjustments were made to care packages to cater for people's changing needs. However, care records did not contain end of life care plans. We raised this with the registered manager to ensure it was addressed.

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.

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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- During the inspection we found breaches of regulation relating to medicines management, care plans and records, training, recruitment and management record keeping. These widespread failings demonstrated the manager did not properly understand regulatory requirements. Systems to assess, monitor and improve the service were not sufficiently robust.
- We found numerous inconsistencies in records which meant we could not be fully assured that appropriate care was provided and made it very challenging to fully understand how the service operated. For example an electronic recording system had not been functioning as intended with gaps in records where we could not establish the care provided. Where paper records were in place, these were also not fully completed. Staff names on paper daily records of care did not always correspond to the names on medicine records, and records were not properly signed meaning it was unclear who had provided care and support some days.
- Records were not readily available for us in the office when we asked for them and there were delays in providing us with key documentation which meant we could not be assured they existed at the time that we requested them. For example, a COVID-19 risk assessment was provided to us an hour and a half after we requested it, however it was not at all relevant to the service and mentioned another organisation throughout.
- The registered office was based in Leeds, but most care packages were being delivered in Somerset. There was inadequate governance to manage this safely. For example, we noted a number of discrepancies between records where it was unclear which staff had been providing care which the manager was unable to adequately explain. We were told a senior care worker had oversight of the service in Somerset but there was no documentation available to detail these enhanced responsibilities.
- We saw some audits were undertaken by the registered manager, but these had been insufficient to ensure a high performing service. Daily records from January 2021 which showed a number of shortfalls had not been audited prior to our inspection visit. Issues with recruitment documentation had not been identified and rectified prior to our inspection.

Systems were not in place to assess monitor and improve the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not identify any impact on people, although there was the potential if robust records were not in

place.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Relatives we spoke with all praised the service and said that good person-centred care was provided to their relatives. They said the registered manager engaged and communicated well with them and took into consideration individual needs and requirements. One relative told us, "The manager is really nice and respectful, [they] has rung a few times to check how things are going, it is a personalised service. Would recommend."
- Staff also praised the registered manager and said they enjoyed working with the service. They said the manager had been supportive of them and given them everything they need to carry out their role.
- Whilst we found the registered manager was kind and caring towards people and keen to provide person-centred care, we were concerned that the organisations lacked transparency, due to conflicting and inappropriate documentation produced in response to some of our requests.

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

- Relatives told us they were kept in touch with by the registered manager and their views and opinions were respected. They said the registered manager had got to understand their relatives and their individual needs. We saw evidence some quality monitoring surveys had been undertaken.
- Staff told us they felt engaged with, and any ideas for improvement were acted on by the registered manager.

Working in partnership with others

- The registered manager gave examples of how the service worked in partnership with other agencies to enhance people's care and a professional and a relative we spoke with confirmed this was the case. However, relationships had also deteriorated with a local commissioner over the way the service had handled an incident.