Exceptional Home Care Ltd

Exceptional Home Care

Inspection report

Manor House
14 Market Street
Lutterworth
LE17 4EH

Tel: 01455207890
Website: www.exceptionalhomecareltd.co.uk

Date of inspection visit:
14 October 2021
24 November 2021

Date of publication:
05 May 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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Exceptional Homecare is a domiciliary care service. The service provides personal care to people living in their own homes or flats. At the time of the inspection there were 17 people who use this service. The service support adults with physical disability and sensory impairment including dementia.

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
The service was not safe. There were no systems within the service to protect people from avoidable harm and abuse. The assessment and management of risk was inadequate. Recruitment protocols did not follow good and safe practice. The provider had not learnt lessons from previous concerns identified regarding the safe care and leadership at the service.

Assessments did not consider people's need regarding known mental health needs, communication etc. This put people at risk of their needs and outcomes not being met. Staff had not received relevant training required to carry out their responsibilities effectively.

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.

Care plans were inadequate. Care was not person-centred. The provider did not have systems in place to ensure information was accessible to all people who used the service. The provider did not have an adequate policy in place for end of life care.

The service was not well-led. Governance systems were poor. Records required for the running of a good care service were not maintained. The provider had not taken action to address short falls within the service following a targeted inspection by CQC. There were no action plans in place to improve the service.

Staff were caring and compassionate. They treated people with dignity and respect.

Rating at last inspection
This service was registered with us on 11/03/2019 and this is the first rating inspection.

Why we inspected
This was a planned inspection based on the date of registration.

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 will continue to monitor the service and discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, safeguarding people from harm, person centred care and good governance.

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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

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 effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

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 findings below.

Inadequate

Exceptional Home Care

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. There was an acting manager at the service.

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 13 October 2021 and ended on 24 November 2021. We visited the office location on 14 October and 24 November 2021.

What we did before the inspection
We reviewed information we had received about the service since its registration. 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
We spoke with two people who used the service and six relatives about their experience of the care provided. We spoke with five members of staff including care staff, a manager from the provider organisation, the acting manager for the service and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two 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.

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 rating 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.

Preventing and controlling infection

● People were not protected from the risk of infection. At the time of our inspection, there were no systems in place for testing staff for COVID-19 as required by the Department of Health and Social Care guidance. There were no risk assessments in place to mitigate risk of non-testing of staff.

Following our inspection, we took enforcement action to respond to this. The provider made improvement and was required to update us weekly on staff testing.

● Staff did not always use required personal protective equipment (PPE) safely. One person told us, "[Staff use of] PPE is very variable too. Some are better than others with handwashing. But I often have to clean equipment that they have left dirty."

● The provider had an infection control policy. However, this was inadequate. The policy did not provide information or guidance to staff on how to protect themselves and people who use the service from the risk of contamination and infection.

Assessing risk, safety monitoring and management

● Risk monitoring and management at the service was poor. The provider had not assessed known risk associated with people's care. This included health conditions which would have a significant impact on people's lives. For example, risk associated with health conditions such as swallowing difficulties and mental health had not been assessed. This meant that staff did not have guidance on how to support people's needs and keep them safe.

● There were no systems within the service on how risks would be identified or how staff would be able to get the right level of support required in their role. This included investigating concerns, whistle blowing and complying with relevant guidance and regulation. This meant people could not be assured risk to their care would be identified nor support available to mitigate risks.

Using medicines safely

● The management of medicines was not safe. The provider did not have an effective medicines policy which could guide staff on how to support people safely with their medicines.

● The provider could not evidence they completed checks which would support the safe management and administration of people's medicines.

Staffing and recruitment

● The provider did not follow safe recruitment practices. They could not evidence that they sought references for care staff before they began to work for the service. Reference checks are part of required

good practice to ensure people are cared for by staff who are suited to work with people who use health and care services.

We found no evidence that people had been harmed however they were at significant risk of harm because the provider did not follow or meet national guidance in relation to infection control, medicines management, assessing risks and safe recruitment. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The way staff were deployed did not always meet people's needs. Some people told us staff did not always arrive at agreed times. This was due to staff shortages within the service and in the wider social care sector.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The provider did not have systems in place to safeguard people from harm and abuse. There were no systems for reporting and recording of concerns raised about the safety and welfare of people who used the service. This included lack of oversight or assurance that referrals were made to appropriate bodies when incidents occurred.
● All care staff had not received up to date training in safeguarding.
● Issues relating to the provision of safe care had been identified prior to this inspection by CQC and the provider themselves. The provider did not take any action to address these issues.

The lack of safeguarding systems within the service placed people at significant risk of avoidable harm and abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 rating 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.

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

- Assessment of needs had not considered people's need with respect to their mental health, changes in physical health, communication etc. This meant there was a risk people's needs and outcomes would not be met. For example, one person's records did not reflect they were at significant risk of choking.

Staff support: induction, training, skills and experience

- Staff had not received some relevant training required to be effective in their role. This included training in safeguarding, person centred care, COVID-19, and the mental capacity act. The acting manager told us they were working on supporting staff to complete required training.
- We received mixed feedback on staff skills and competence. Some people had a good experience, others didn't. A relative told us, "The care is very dependent on who comes as they are struggling with recruitment, some staff are better than others." Another relative said, "There appears to be a need for training around professionalism, hygiene and the use of equipment."

Supporting people to live healthier lives, access healthcare services and support

- The service did not support people to access support from health care agencies or other professionals. They did not share information about changes in people's needs or follow up input from other professionals to ensure the care people received was consistent.

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.

●Mental capacity assessments did not follow good practice guidance. For example, one person's assessment did not show how a decision would be made in their best interest or the date the assessment was completed.
● People told us staff always asked for consent before providing care to them.
● At the time of our inspection the service did not support anyone who was being deprived of their liberty.

Supporting people to eat and drink enough to maintain a balanced diet
● Where people required support with their nutritional needs, staff ensured they provided this support according to people's assessed needs. One person told us, "They [staff] prepare my breakfast each day and they know how I like it. I am happy with my care overall." Another person said, "They help with food preparation and do it correctly."

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 rating inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People told us staff did their best for them. However, staff did not always have time to communicate and listen to them. A staff member told us their rota schedule did not allow them sufficient time to get to people's homes and affected the time they could spend with the people they support.
- The provider did not have systems within the service to ensure people had information about external organisations that can support them with their care, support and advocate for them where this had been required.

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

- The systems within the service did not always support staff to respond to people's changing needs quickly. For example, the provider did not provide support to a person who used the service and their relative to ensure they could access support that met their current health needs. The provider took action to support them following our inspection.
- People told us staff were caring and did their best to support them. Staff were compassionate and kind. One person told us how a staff member had gone out of their way to support them to attend [details].

Respecting and promoting people's privacy, dignity and independence

- People told us staff treated them with respect. One person told us, I like the staff who have provided very good care for me and always treat me with respect and consider my opinions."
- We received mixed feedback from people on how staff promote privacy. The systems within the service did not assure us that people's information were treated with confidentiality.

Inadequate

Is the service responsive?

Our findings

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

This is the first rating inspection for this newly registered service. This key question has been rated 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

- Care plans were inadequate. The provider told us they had moved to electronic care plans. Not everyone who used the service had their information on the electronic care planning system. Some documents containing care planning information could not be found. Care plans in paper format were incomplete. This meant there was insufficient information available to meet people's needs.
- Care planning was not holistic. Assessments did not consider the overall needs of the individual who needed care and support. They did not include information of other people and professionals who were involved in a person's care and how this impacted on the overall wellbeing of people's lives. For example, one person's care plan did not include their mental health need nor the support they received from health professionals and other social care organisations.

The provider had failed to ensure people received appropriate person-centred care that met their needs. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- The provider did not always respond satisfactorily to people's complaints. They did not always follow their complaints policy. We saw a complaint to the service was acknowledged but there was no evidence of an investigation or an outcome sent to the complainant.

The provider had failed to establish and operate a system to record, investigate and respond to complaints about the service. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us their care staff and the acting manager do their best to resolve their concerns, however the systems within the service do not always support the acting manager and staff. One person told us, "[Acting manager] does listen and tries to resolve issues. She really tries to improve things but she is new."

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 provider did not have systems in place to follow the Accessible Information Standard. They did not

have policies and protocols in place which would support them to provide information in a variety of formats to meet people's communication needs.

End of life care and support

● The provider had an end of life policy. However, this was inadequate. The policy did not provide information or guidance to staff on how to support people who may be coming to the end of their life.

● At the time of our inspection there was one person who was approaching the end of their life. Their care plan was of a poor standard, office staff could not find where relevant information about their care may have been recorded. Their relative told us they had a poor experience of support from the service.

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 ratings 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.

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

- The service was not well-led. Systems for governance were poor and could not be used to maintain effective oversight of the service. For example, medicines audits were incomplete and did not reflect whether people's medicines were managed safely or not.
- The systems within the service did not promote person-centred and safe care. They did not always promote the well-being of people who used the service.

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

- The service did not have a registered manager. An acting manager was in charge of the service. People told us the acting manager was kind and caring. The provider did not have adequate support and training in place to enable the acting manager to understand and carry out the requirements of their role effectively.
- The systems for oversight were poor. The provider did not follow good practice to monitor the quality of care people received. They told us this was the responsibility of previous managers of the service. There were no systems or plans in place to ensure quality monitoring and continuity if managerial staff left the service.
- Records were not maintained. For example, the managers could not find records for safeguarding. Incidents relating to people's care were not recorded. We could not be assured that relevant incidents which should be notified to CQC had not occurred at the service.

Continuous learning and improving care

- The provider had not taken steps to learn and improve care delivered by the service. The CQC completed a targeted non-ratings inspection in September 2020 where we identified issues relating to the safety and leadership of the service. At this inspection, we found the issues remained. This meant that lessons were not learnt from previous failings and no systems and processes were implemented to prevent reoccurrence.
- The nominated individual completed a quality monitoring visit to the service in August 2021 where they recorded that they had an action plan in place for improving the service. At this inspection, they were unable to find and share the action plan with us.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider did not work in partnership with other professionals involved in people's care. This included social workers and district nursing staff.

The provider had failed to operate systems or processes to assess, monitor and improve the quality and safety of the service provided. They did not maintain accurate, complete and contemporaneous records of people's care. Feedback was not actively encouraged. These issues constitute a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received appropriate person-centred care that met their needs.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Lack of safeguarding systems within the service placed people at significant risk of avoidable harm and abuse.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to establish and operate a system to record, investigate and respond to complaints about the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate systems or processes to assess, monitor and improve the quality and safety of the service provided. They did not maintain accurate, complete and contemporaneous records of people's care.