

4Life Healthcare Limited

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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?

Insufficient evidence to rate

Is the service caring?

Insufficient evidence to rate

Is the service responsive?

Insufficient evidence to rate

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

4Life Healthcare Limited is a domiciliary care agency providing personal care to people in their own homes. At the time of the inspection one person was receiving support with personal care.

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

The care plan and risk assessments we viewed did not provide enough guidance for staff to keep the person safe from harm. Staff had not had training on the person's specific health needs, or how to provide end of life care if a person's health deteriorated. These are ongoing concerns from our last inspection. The provider has now put in place competency assessments and spot checks to assess staff practice.

We found staff had not been safely recruited to ensure they were of good character. Poor quality recruitment processes had continued since our last inspection.

The person using the service felt safe. We had not received any allegations of abuse since the last inspection. There had been one complaint, and the person felt this has been dealt with appropriately. Due to a lack of incidents since the last inspection, we were unable to review if the provider's response to incidents had improved.

At the last inspection medicines were not managed safely. At this inspection, staff did not support anyone to take their medicine. Staff did support moving the medicine from the prescribed container into another box. They had no guidance in place to ensure this was done safely and in accordance with current best practice standards and guidelines.

Staff had access to personal protective equipment to reduce the risk of COVID-19 transmission. Staff engaged regularly with the COVID-19 testing. Two staff who provided the majority of the care for the person had not had COVID-19 training.

We identified that one external professional referral had been needed. This had not been completed until prompted by the inspection team. This left the person at risk of unsafe care.

The service was not providing enough support with eating, drinking and social support for us to make judgements in these areas. The service did not support anyone who needed support to make decisions. We were therefore unable to assess the provider's effectiveness of following the Mental Capacity Act. This is legislation for people who may not be able to make decisions for themselves.

The person that used the service spoke positively about the care provided, and kindness of staff..

At the last inspection we had concerns about care planning, risk assessments, staff training and the safety of recruitment at the service. We found these areas still needed further improvement. The provider did have an

action plan to improve these areas; however, since our last inspection limited action has been taken.

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

Rating at last inspection

The last inspection was rated Inadequate (Published 14 January 2021)

Why we inspected

The last inspection was rated inadequate, and with breaches of regulation. This was a routine inspection to assess if required improvements had been made.

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 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 ongoing breaches in relation to Regulation 12 (Safe Care and Treatment), Regulation 17 (Governance) and Regulation 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we have asked the provider to take at the end of this full report. We have sent the provider a warning notice. A warning notice gives a timescale to make the required improvements.

Follow up

We will review future information we receive about this service. We will return to visit as per our re-inspection programme and to review compliance with the warning notice. 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?

The service was not safe.
Details are in our safe findings below

Inadequate ●

Is the service effective?

We have not provided a rating for this domain.

Insufficient evidence to rate

Is the service caring?

We have not provided a rating for this domain.

Insufficient evidence to rate

Is the service responsive?

We have not provided a rating for this domain.

Insufficient evidence to rate

Is the service well-led?

The service was not well-led.
Details are in our well-led findings below.

Inadequate ●

4Life Healthcare Limited

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 team consisted of an inspector and an inspection manager

Service and service type

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

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

Notice of inspection

We gave the service 48 hours' notice of visiting the office location. We gave notice of the office visit, because it is a small service and we needed to be sure that the registered manager would be available to support the inspection.

What we did before the inspection

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We considered any information we had received since the last inspection. We sought feedback from partner agencies. We used all of this information to plan our inspection.

During the inspection

We spoke with one person who used the service about their experience of the care provided. We also spoke

with three members of staff and the registered manager.

We looked at the care records of one person. We reviewed other records in relation to the management of the service. These included four staff recruitment files, training records, quality monitoring audits, and the provider's policies and procedures.

After the inspection

We continued to seek clarification from the provider to validate evidence found. The provider also sent us their current action plan.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At the last inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- At the last inspection, we found the service did not always recruit staff safely. At this inspection, we had concerns about three out of the four staff recruitment files we looked at. Two of these staff were no longer working at the service, but had been employed since the last inspection and had worked with the person that the service was currently supporting.
- Our concerns included not gathering suitable references from previous employers, not gathering employment histories and starting work before the Disclosure and Barring Service (DBS) check had been returned. This did not follow 4life Healthcare Limited's policy and left the person at risk of care from staff of poor character.
- At this inspection, the provider had created an action plan to improve the safety of recruitment. We raised concerns about recruitment at the last inspection and there has been a lack of effective action to improve this

At our last inspection the provider had failed to recruit staff safely. Poor quality recruitment meant we were not assured that staff were safe to support people. This was a breach of regulation 19 (fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

- The service supported one person with personal care. This person advised that staff arrived on time and they had not had any missed visits.

Assessing risk, safety monitoring and management

- At the last inspection, we found care plans did not provide enough guidance to staff to support the person safely. At this inspection, care planning had improved; however, we identified some areas that required further development. This is because the person's needs were not fully described to staff to help them to provide safe care. Care plans did not describe how to support specific health needs, this was raised at the previous inspection and had not been resolved.
- At the last inspection, the service did not have risk assessments in place. At this inspection, risk assessments had been put in place. However, these were generic and not person centred. This increased the risk of the person receiving unsafe care.
- Staff had not been following usual procedures with a person's mobility equipment. There was no risk assessment for this potentially unsafe practice. Professional occupational therapy advice had not been sought for the four months that this potentially unsafe moving and handling had occurred.
- Staff had been instructed to use equipment that had not been serviced. This risks the equipment failing and causing injury to the person or staff using it.

- Following the last inspection, the provider had an action plan in place which recognised that care planning required further improvement. We remain concerned that since our last inspection sufficient improvement has not been made.

At our last inspection the provider had failed to keep people safe from harm. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

Preventing and controlling infection

- Two staff who often provided care, had not received COVID-19 training.
- Staff were provided with personal protective equipment to keep the person safe from COVID-19 transmission. Spot checks were carried out to ensure that staff were using this PPE correctly.
- Staff had been supported to access COVID-19 vaccines and were taking part in weekly COVID-19 testing as per government advice.

Systems and processes to safeguard people from the risk of abuse

- The person using the service advised they felt safe. They said they had recommended the service to other people.
- The service had a safeguarding policy in place. This guided staff on how to respond if they had concerns about abuse.
- At the previous inspection, we had concerns that this policy was not being followed. At this inspection, there had been no allegations of abuse so we could not assess if the provider would now keep people safe from harm and abuse by following this policy.

Using medicines safely

- At the time of the inspection, the service was not providing support with medicine administration. However, staff were supporting the person to put their medicine from their prescribed boxes into a different box container. There was no care planning to guide staff how to do this safely.
- At the last inspection, we had concerns about the safety of medicine administration. We have not been able to assess whether changes have been made to the safety of medicine as staff did not support people to take their medicine at this inspection.

Learning lessons when things go wrong

- Since the last inspection, the provider had received one complaint. They had investigated this and the person was happy with the outcome.
- At the last inspection, we were concerned that lessons were not always learnt when things went wrong. The service has been supporting less people since the last inspection and incidents have not occurred. We have therefore not been able to analyse whether sustained improvements have been made in incident management

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 into the 'effective' domain. Due to the limited evidence in this area, we have not been able to provide a rating.

Staff support: induction, training, skills and experience

- At the last inspection, we were concerned that staff did not have training on people's specific health conditions. At this inspection, records showed and staff confirmed that this was still not in place.
- At the last inspection, we were concerned that staff were not trained on how to provide end of life care. The service was not currently supporting anyone with end of life care needs, however we would expect staff to have had this end of life training, to support if a person's health deteriorated.
- Improvements had been made to competency assessing staff by completing spot checks of their practice and reviewing care records.

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

- The care planning in place at the service has improved since the last inspection. However, required further improvements to meet current expected standards. This has already been reported in the 'safe' domain of this report. The provider had created an action plan to work towards this in future but this action plan had not created sufficient expected improvements.
- The service was only supporting one person. We have not been able to assess if sustained improvement has been made to meeting current standards of care.

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

- We identified that one external health professional referral had been needed. This had not been completed. We asked the provider about this and they then contacted the professional. We are concerned that this contact had not occurred before our inspection. This could affect the person's safety
- There had been no other examples where referrals to external health professionals were needed, so we can make no further judgements in this area.

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

- The service was not supporting enough people with eating and drinking. Therefore we were unable make a judgement of this.

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.

- Nobody using the service needed help with making decisions. We have therefore been unable to make a judgement in this area.

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 into the 'caring' domain. Due to the limited evidence in this area, we have not been able to provide a rating.

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

- The person using the service, explained that staff that support them were kind and caring. They advised they had recommended the service to others.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- The person using the service advised that the care staff knew how to support their daily routines, but still helped them make daily decisions about their care.
- Staff described how they supported the person in a dignified way. Staff explained that they had received training in equality, however there was no evidence of this in the provider's training records.

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 into the 'responsive' domain. Due to the limited evidence in this area, we have not been able to provide a rating.

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

- Some improvements had been made to care planning. There was personalised guidance about routines for staff to follow.
- We received feedback that the person was able to have choice and control over their own daily routines.

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.

- Nobody using the service had communication needs. We therefore have been unable to assess support in this area.

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 person using the service for personal care support, did not have regular social support. We have therefore been unable to make a judgement in this area.

Improving care quality in response to complaints or concerns

- There has only been one complaint since the last inspection. We spoke to the complainant, and they were happy with the outcome and records suggest it was dealt with in a satisfactory way. This has already been responded to in the 'safe' domain.

End of life care and support

- The service was not supporting anyone with end of life care needs.
- At the last inspection, the service was supporting people at the end of their life. However, staff had not been trained in how to provide end of life care. Staff had still not received training in case a person's health deteriorated. This could place people at risk of receiving inappropriate or unsafe end of life care.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- At the last inspection, we highlighted concerns about the quality of care planning. At this inspection, the quality of care planning had improved; however, further work was required to meet the expected standard of 'good' care. Audits of the current care plan had occurred. However, audits either did not recognise the improvements needed, or the audits recognised improvements needed but action had not been taken to resolve issues. The leadership was therefore ineffective at creating quality improvement.
- At the last inspection, we were concerned about the lack of risk assessments at the service. At this inspection, risk assessments were in place. However, these were generic and not person centred. They did not sufficiently assess and reduce the risk. Leadership had not effectively responded to our concerns at the last inspection.
- At the last inspection, we had concerns that staff were not trained in how to support people's individual health needs and end of life care. This remained a concern at this inspection. The leadership at the service had not put in place training for a specific health need or end of life care.
- At the last inspection, the service had not safely recruited staff. This remained a concern as three out of the four staff files were not safely recruited. The 4life Healthcare Limited policy was still not followed to ensure staff were safely recruited.
- At this inspection, the service had an action plan in place to make further improvements to care provided. However, we have flagged the above concerns over a year ago. So sufficient action has not been taken to make improvements in a timely way.

At our last inspection there was poor governance at the service. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, there had been insufficient action taken to improve; care planning, risk assessments, training and recruitment at the service. This meant the provider was still in breach of regulation 17.

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

- The person using the service and staff had been engaged with to improve the service. This was through staff one to one supervision meetings and surveys.

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

outcomes for people

- The service was supporting one person. This person felt staff arrived on time and were kind to them. They had also been engaged with for feedback about the service.

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

- There has only been one known complaint since the last inspection. The complainant was happy with the outcome. A record of the complaint suggests it was dealt with in a satisfactory way.

Working in partnership with others

- The service was required to contact one professional for the current person they support. This contact had not been made, leaving the person at risk of unsafe care. The professional was only contacted when prompted by the inspection team.
- At the last inspection, the service did not work in partnership with others. We have only one example during this inspection, so are unable to comment on the overall improvement in this area.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>At our last inspection the provider had failed to keep people safe from harm. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12</p>
Regulated activity	Regulation
Personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>At our last inspection the provider had failed to recruit staff safely. Poor quality recruitment meant we were not assured that staff were safe to support people. This was a breach of regulation 19 (fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19</p>

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>At our last inspection there was poor governance at the service. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, there had been insufficient action taken to improve; care planning, risk assessments, training and recruitment at the service. This meant the provider was still in breach of regulation 17.</p>

The enforcement action we took:

You can see what action we have asked the provider to take at the end of this full report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.