Leonard Cheshire Disability

Living Options Outreach - Domiciliary Care

Inspection report

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Date of inspection visit:
07 February 2023

Date of publication:
28 March 2023

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Living Options Outreach – Domiciliary Care can provide personal care and support for up to 3 people with a range of disabilities. At the time of our inspection there were 2 people using the service. Both people received personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

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

Right Support: People were not always supported to have maximum choice and control of their lives. People chose how they wanted to spend their days and were supported by staff to follow their interests. However, if staff were not available, people could not always go out when they wanted, even though they were allocated additional funding for one-to-one support.

Right Care: Care was personalised to meet people's needs. People were cared for by staff who knew them well. People's preferences, likes and dislikes had been documented in their care plans which staff followed.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people using services were able to lead confident, inclusive and empowered lives. Lack of oversight at the service had resulted in people being harmed. Concerns raised were not always listened to or acted upon by the provider.

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 good (report published 11 May 2019).

Why we inspected
The inspection was prompted in part by notification of incidents of alleged abuse affecting people who used the service. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incidents. However,

the information shared with CQC about the incidents indicated potential concerns about the management of risks. This inspection examined those risks.

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 has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the well led section of this report. You can see what action we have asked the provider to take at the end of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Living Options Outreach – Domiciliary Care on our website at www.cqc.org.uk.

Enforcement
We have identified a breach in relation to the governance and management oversight of the service. Please see the action we have told the provider to take at the end of this report.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not well-led.

Details are in our well-led findings below.

Living Options Outreach - Domiciliary 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 Health and Social Care Act 2008.

Inspection team
The inspection was undertaken by 1 inspector.

Service and service type
This service provides care and support to people living in their own home, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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 not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We received information of concern about the service which the provider sent us and which triggered this inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with 2 people and a relative about their experience of the service. We spoke with the interim operations manager, operations manager, acting manager and 2 care staff.

We reviewed a range of records including 2 care plans and medication records. We looked at 1 staff file in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed. During the inspection, we requested and received additional information from the interim operations manager by email.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People had not been protected from the risk of abuse or harm due to incidents that had occurred at the service. The provider was not aware of these incidents until people had shared their concerns with staff, so there was a delay. Systems were not sufficient to protect people from the risk of harm.
- If things went wrong, actions had not always been taken, improvements made or lessons learned.
- Concerns were raised by people and their relatives about some members of staff and their attitude. A relative told us, "We informed senior staff, but they just said they weren't there, so hadn't seen it. The whole management has not been interested or listened to our concerns, they have been very apathetic. We think the new manager sounds good and she or the deputy will visit every week which should help".

Systems had not been effectively established to protect people from the risk of abuse or harm. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- One person said, "It's a lot quieter here now. I feel safe the majority of the time and I do feel safe now".
- Actions had been taken by the provider to protect people from the risk of further harm. The local safeguarding authority was undertaking an investigation and liaising with the police.
- Staff completed safeguarding training and knew what actions to take if they had any concerns. One staff member said, "Safeguarding is in place to protect the people we support, and ourselves, everyone really".
- We reviewed the provider's safeguarding children and adults policy and this provided guidance for staff.
- Incidents that had recently occurred at the service were being overseen by the senior management team. Time had been spent by staff to reflect on these incidents and what could have been done differently.

Assessing risk, safety monitoring and management

- People's risks had been assessed appropriately; care plans provided information for staff on how to mitigate risks, which was followed.
- Risk assessments we reviewed included support people required with personal care, mobility, and eating, for example. In 1 care plan, it stated the person had difficulty swallowing certain types of food and medicines. High risk foods such as chips and burgers were to be avoided. We observed this person having their lunch. The food was chopped into small pieces, and a straw placed in their drink mitigated the risk of them drinking too quickly.

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 Mental Capacity Act (MCA). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

● We found the service was working within the principles of the MCA. People had capacity to make decisions and no-one was deprived of their liberty.

Staffing and recruitment
● Staffing levels were sufficient to meet people's personal care needs, although sometimes staff were not available if people wanted to go out. A relative said, "The staff started intimidating her, saying she got more one to one hours than anyone else, you should be grateful. These are the staff she knows quite well and they were under pressure too, but she bore the brunt of it". There was at least one member of staff to support both people living at the service. At night, a member of staff would sleep at the premises and be available if people required help and support.
● One staff member said, "It's different working here, lone working. I sometimes feel isolated, but I can call someone, there is always someone on call".
● New staff were recruited safely. The staff file we reviewed showed all relevant checks had been completed, and references obtained. A Disclosure and Barring Service (DBS) check was on file. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● Medicines were managed safely.
● People received their medicines as prescribed. Medication administration records confirmed this and were completed appropriately.
● Medicines to be administered as required (PRN) were given in line with the provider's policy. For example, paracetamol given for pain relief was administered within safe time frames and the PRN protocol for this person advised staff of the dosage.
● All staff supporting people at the service had completed medicines training. Staff competency to administer medicines was completed annually and records confirmed this.
● Regular medicines audits had not identified any concerns.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Governance and oversight of the service was poor. Concerns raised by a person and their relatives about the attitude of some staff had not been addressed. A relative said, "Leonard Cheshire has not followed up on a lot of things they should have done. We thought [named person] was safe, but now she isn't".
- There was no registered manager in post at the time of this inspection. An acting manager had taken over the day-to-day running of the service and had only recently transferred over from one of the provider's other services. The acting manager was supported by members of the senior management team. A new manager was due to commence employment the week after the inspection.
- Staff had not been supported by the management team until recently. One staff member explained why they did not feel supported then, and added, "I'm feeling quite positive now though and change is always good".
- The management of the service, before the last manager de-registered, was overseen by a senior member of staff. They told us they had not felt supported in their role and said, "I did not see the manager often. I told someone at head office and they said the manager should come and see us at least half a day a week, but this did not happen".
- There was a lack of oversight of the management of the service. Staff were due to have supervision meetings with their line manager every three months. For one member of staff who had worked at the service, this had not happened. The provider's performance management policy stated, 'All employees have regular development and support meetings'. Records showed they only had one supervision meeting in 2022 and an annual review. Another member of staff told us, "There was a time when I didn't have supervision for about 18 months. No-one came to visit from head office. Sometimes the manager was due to visit and then didn't turn up. I have had support from [named staff member]. I've met the new manager too and she has assured me I will be supported".
- A system of audits had been implemented to monitor and measure the service but these were not effective to identify areas in need of improvement. A local action plan included some information on staff training, supervision and premises management. Although visits by senior managers were recorded, in some instances, these lacked detail about what had occurred and any actions that were required.
- Risk assessments had not been completed for staff who were working unsupervised. This put staff at risk of harm as potential risks had not been identified. We reviewed the provider's lone working policy. This stated the need to risk assess staff who worked alone and also, 'Appropriate levels of supervision are provided'. One staff member told us, "There are times when we work alone. Sometimes there might be someone else in the house, but if they go out, then there is only one member of staff. On a night shift there is

only one person all the time. You can sleep, but if you've worked all day too it can be long and then you have all evening on your own".

There was a lack of governance systems to ensure the quality and safety of the services provided to people. Quality audits lacked detail to monitor the service effectively or to drive improvement. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were involved in all aspects of their care. For example, there were plans to have another person join them in the house, and people would meet them beforehand.
- Although formal house meetings did not take place, people did share their views with staff and were asked for their feedback informally. People chose what they wanted to have for their meals and how they wished to spend their time.
- People's diverse needs were catered for and they were supported in line with their needs and preferences. One person used a speech-generating device. Messages could be typed on a keyboard and the message displayed so the person could communicate with others. Staff had learned sign language to communicate with this person.
- Notifications that the provider was required to send to us by law had been received.

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

- People received personalised care that met their needs and preferences. One person said, "I love it here". Another person told us how they spent their week, attending a day centre a couple of times and going out on other days. They had a tablet for reading and messaging friends.
- People told us they had gone out for Sunday lunch at one of the provider's other services. There were plans to encourage people to visit these services more regularly to further friendships and enable them to go out more.
- People received additional funding so they could choose what they wanted to do, supported by a member of staff. For example, one person liked to help with the shopping and food preparation. They assisted with the on-line food shopping.
- Care plans detailed people's likes and dislikes. Staff knew people well and how they wished to be supported.

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 management team demonstrated their understanding of duty of candour. They told us of actions that had been taken as a result of recent incidents at the home, and how they had kept in touch with people's relatives.
- These incidents were in the process of being investigated, and people's families were updated on what was happening.

Working in partnership with others

- The service worked in partnership with a range of agencies including health and social care professionals.
- As a result of incidents that had occurred, the senior management team were in regular contact with the local safeguarding authority, police and CQC.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not effective to protect people from the risk of abuse or harm. Regulation 13 (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of governance systems to ensure the quality and safety of the services provided to people. Quality audits lacked detail to monitor the service effectively or to drive improvement. Regulation 17 (1) (2)(a)(b)(e)(f)