First Choice Medical Solutions 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 well-led?	**Inadequate**

Summary of findings

Overall summary

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.

About the service
First Choice Medical Solutions Ltd is a domiciliary care agency. It provides personal care to people living in their own houses and flats and supported living. It provides a service to older adults, younger adults and children who may live with sensory or physical disabilities, people with dementia or learning disabilities and autistic people. At the time of this inspection 28 people were using the service.

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

Right Support
People were not always supported to have maximum choice and control of their lives. Staff had not supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Staff needed further training to develop their skills and understand how to support people with a learning disability or dementia in their best interest.

Staff were not recruited through safe recruitment processes. This increased the risk that people were not supported safely by staff with the right skills and experience.

Staff were at times late arriving to support people. Relatives told us the office staff failed to alert them of staff lateness, which caused upset. This was not improved even after they repeatedly raised this issue with the office staff.

Right Care
Staff needed further training to understand how to provide people with safe and personalised care. People were not always protected from the risk of abuse. This was because safeguarding systems and processes were not embedded in staff's daily practice. Risk assessments needed further developing to ensure they gave enough guidance for staff in how to mitigate risk.

The registered manager carried out regular audits to help ensure medicines were administered safely. They failed to identify in their audits concerns reported by relatives of people who repeatedly found medicines on

the floor. Staff were not retrained in medicine administration or had their competencies checked when they made an error.

Right Culture
The registered manager failed to ensure they had a full understanding of their management responsibilities. They had little oversight of the service and they failed to ensure people received support safely. They did not promote a positive culture through their leadership and support for staff. The provider did not evidence organisational visions and values to underpin the principles of 'Right support, right care, right culture.' This guidance provides a framework for the planning and delivery of care and support for adults with learning disabilities and autistic people.

The registered manager did not demonstrate an open and transparent approach. Information requested during the inspection was not always accurate and, in some circumstances, had been developed only in response to us raising concerns.
People were in general happy with the support they received and felt safe. However, we found that not all processes and systems operated by the provider promoted safe and quality care.

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 rating for this service was good (published 30 April 2022)

Why we inspected
We received concerns in relation to unsafe recruitment processes, lack of support and training for staff. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. 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 inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for First Choice Medical Solutions Ltd on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safeguarding, recruitment, staffing skills, notification of incidents and good governance.

Please see the action we have told the provider to take at the end of this 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.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 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 well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

First Choice Medical Solutions Ltd

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors.

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 provides care and support to people living in one 'supported living' setting, 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

The inspection activity started on 28 November 2022 and ended on 15 January 2023. We visited the office location on 28 November 2022 and 05 December 2022. We also visited the one supported living service on 15 January 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We received feedback from social care professionals about the care people received. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We spoke with commissioners and local safeguarding authority to gain feedback about the service. We used all this information to plan our inspection.

During the inspection
We spoke to 2 people and 6 relatives of people using the service. We spoke with 8 staff members including the compliance manager, the registered manager and care workers. The registered manager was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at 3 people's care plans, medicine administration, 19 employment files, supervision and training records and various other management related documents.

Inadequate

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 inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- People were not protected from the risk of abuse. This was because staff knowledge about what constituted abuse was basic. Whilst they could describe physical abuse or financial abuse, the incidents we found during this inspection demonstrated gaps in the registered manager and staff knowledge of what constitutes abuse and neglect and the actions needed to safeguard people from further risks of abuse.
- The registered manager failed to report to CQC when they were made aware of a safeguarding concern where a person had their body hair shaved without seeking their consent or any consideration of their best interest. Staff had not recognised this as a safeguarding concern and had not raised this with the registered manager or the local authority safeguarding team until the person's family member raised their concerns. We found other incidents where safeguarding allegations were made, and the registered manager and provider failed to investigate or report to the safeguarding authority and CQC. This increased the risk of people being open to further abuse.
- Relatives had mixed views about people being safe. One relative told us, "I don't feel [person] is always safe. This is because staff are not well trained to know how to deal with [person's] needs." Another relative said, "Overall the support is safe but some of the processes and some incidents make me feel it's not safe."
- The culture within the service was not open or transparent. The registered manager was not able to demonstrate to us where they had discussed safeguarding concerns, outcomes or follow up actions with staff. When an incident, complaint or concern was raised, a message was sent to all staff instructing them of what to do in future but there was no discussion about the outcomes or potential learning for staff and no checks on staff understanding of the issue. This was a missed opportunity to identify through reflective practice what had gone wrong and what practices had to be changed to prevent reoccurrence. This placed people at an increased risk of further harm.
- Some people's care records indicated if they had mental capacity to make decisions in some areas, however, assessments were not carried out for specific decisions.. For example, a person had dementia and was refusing meals. There was no assessment of their capacity to check if the person understood the risks of not eating. This meant people were not always safeguarded from the increased risk of harm.

The provider and the registered manager failed to operate effective safeguarding processes, and this left people at risk of abuse. This was a breach of regulation 13 (safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- One person told us they felt staff were supporting them and other people in the supported living environment safely. They said, "I feel safe when staff are around. They know what they need to do when [other people living there] are anxious." Two relatives felt people were safe with staff.

Staffing and recruitment

● The provider failed to ensure staff were recruited in a safe way. Most staff working had been recruited from overseas through sponsorships. References to support their application had not always been sought or verified; applications for employment were not completed and important information about visas and work permits were not always saved in staff files. This meant there was a risk that not all the staff had the right to work in the UK or had the necessary skills and experience to meet people's needs safely.

Failing to operate robust and safe recruitment processes was a breach of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff arrival times for care call visits varied by up to an hour. This meant people sometimes had their care call visit late. This had been raised previously by some people. Staff were not deployed in a way that ensured all care calls visits were attended to in a timely way. Relatives told us it was a regular occurrence that they were not alerted when staff were running late. They also told us that due to communication breakdown staff sometimes turned up for visits when these were cancelled.

● People told us they could rely on staff and staff were always present, day and night in the supported living environment.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

● Risk assessments were not always clear or coordinated and needed further detail to give staff more guidance about how to manage risk and provide care safely. For example, where people were at risk of falls, risk assessments needed more detail about what measures were in place to mitigate such risk.

● Some people required staff to administer their medicines. Staff received training, however in most cases the training was on-line and there was no evidence that they had their competencies observed. The registered manager told us they observed staff administering medicines, however this was not always recorded.

● One person told us they were happy with the way staff supported them with their creams and medicines. One relative told us changes to people's medicines were delayed at times due to poor communication from office staff. This was an area in need of improvement.

● People were supported by staff to keep their bedrooms clean. Staff followed good infection control measures and adhered to the provider's policy when wearing personal protective equipment (PPE).

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to 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

- Staff coming from overseas told us they completed on-line training whilst they were still in the country of their origin. We saw that in some instances this was months before they arrived in the UK and commenced employment. On arrival staff had an induction into their day to day work and they were told what was expected from them. However, their knowledge about the training they done on-line has not been checked.
- Staff supported people with dementia, people with learning disability and autistic people, but they had little understanding about how to effectively support people. The training they received was only an awareness course of mental health, dementia and learning disability done on-line. The registered manager failed to ensure staff had a good understanding and were skilled in supporting people with this need.
- Staff had not had their competency assessed regularly and had no meaningful one to one support, supervision to discuss their performance, agree training needs or further development.
- Relatives told us, they felt staff needed further training to understand how to support people with dementia or people with learning disabilities and autistic people. One relative told us, "Staff are really nice, but they need more training." They went on to tell us their relative would say no to the questions asked, for example, if they were hungry and they needed meals placed in front of them to eat. Staff had not always done this. This was an area in need of improvement.

The lack of training and support for staff was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

● Staff told us about the importance of offering people choices and listening to people, however they were unsure who could make decisions in people's best interest.
● Some people's care records detailed they lacked capacity around their finances, personal care or understanding risks, however there was no MCA assessments in place to show how was this assessed and if this had been reviewed. Relatives told us they had limited access to daily care records since these were electronic, therefore they felt less involved in people's care to support decision making.

Supporting people to eat and drink enough to maintain a balanced diet; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Some people needed support from staff to ensure they had food and fluid intake. Care plans did not give enough guidance to staff to know people's likes and dislikes or meal preferences. Relatives told us staff had not always showed an understanding of how important good nutrition was for people.
● Staff alerted relatives in case people run out of food, however they did little to support in case relatives could not replenish food stocks immediately. For example, one person had water on their cereals in the morning instead of milk and they run out of bread. Although staff were asked by the person's relative to purchase these, staff refused saying it was against company policy. This did not promote good nutrition for people. The registered manager told us they were not aware of these concerns raised.
● Some staff actions demonstrated little understanding of safe food hygiene practices. For example, in one instance staff gave people out of date food. This was an area in need of improvement.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with health professionals involved in people's care. When people's relatives were involved and supported people to attend doctor's appointment in some occasions changes to people's medicines were not promptly implemented. Communication from relatives were not effectively passed to staff who supported people, and this caused delays in acting on health professionals advice.
● Further improvements were needed to develop guidance and support plans for people who needed staff's support to have healthier lives.
● People's needs were assessed prior of using the service. A care and support plan were developed for each person to help guide staff in how to meet people's needs. Reviews of people's needs were not always involving relatives. Some relatives told us they were having difficulties accessing care plans or daily notes for people and they did not feel involved.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- The provided failed to evidence credible organisational visions and values to underpin the principles of 'Right support, right care, right culture' guidance. This provides a framework for the planning and delivery of care and support for adults with learning disabilities and autistic people. First Choice Medical Solutions Ltd provided supported living services to people with a learning disability and autistic people, however they were not following best practice guidance in their management and staff practices.
- The registered manager sought people's views and opinions, but these were not acted upon. For example, some people had repeatedly said staff arrived late to provide their care and did not always inform them of the delay. Another person wanted a male staff removed from their care, which was not acted upon. Other comments included people who wanted to have a 'proper shower' and people who were not happy with the conclusion of their complaint. The registered manager told us these views were captured in a 'You say, we did,' however, the most recent response addressed none of the above issues.
- The provider failed to promote an inclusive and empowering work environment. Leadership was not effective and support and supervision for staff did not ensure understood the requirements of their role. Staff were committed to achieving good-quality care but most of them were new to working in care in the UK. Staff were not provided with the knowledge or guidance to enable them to provide personalised care and support to people. Some staff told us they felt they were not listened to.
- Staff meetings were not regularly held with all staff to provide them the opportunity to express their views and opinions on the day-to-day running of the service. Meeting minutes did not demonstrate that staff were provided an opportunity to discuss wider issues arising from safeguarding concerns, complaints, share their views and opinions or agree shared objectives as a collaborative team.
- An independent training and development survey had been completed in February 2022 for all staff to assess whether they felt adequately equipped and supported to perform their role. Some staff said they did not receive additional training in specific areas such as dementia, they had not received supervision and some staff had not received an appraisal. Staff were unaware of the results from the training survey, improvements needed within the service or ongoing safeguarding investigations.
- Training provided to staff only covered areas considered mandatory by the provider and were not tailored to people's needs or staff's individual training needs.
- Relatives told us they raised concerns with the office staff when needed but these concerns were often not addressed. There were no records kept within the service to evidence that concerns were recorded, and actions were implemented to make the necessary improvements.

● Incidents and accidents involving people with a learning disability were responded to individually and reported to health and social care professionals. However, there was no analysis done by the registered manager to understand the nature of incidents happening across the service. They had not looked for trends and patterns which could indicate staff training needs or if the same staff members were present when these incidents happened. This exposed people to further risk of harm.

The provider failed to ensure they had systems and processes in place for people to receive safe and good quality care from staff who were adequately trained and skilled in meeting people's needs safely. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provider who was also the registered manager did not demonstrate a sufficient understanding of quality monitoring and their knowledge around the management of the service and oversight was limited. They were unable to detail the improvements needed in order to provide safe and personalised care. Systems were in place to monitor the safety and quality of care provided but were not effectively used. During the inspection, key information requested, was provided by the service manager. The registered manager was not able provide information requested and was not able to detail what was in place to mitigate risks or drive improvements.

● The provider told us a robust electronic logging system was in place, so they could monitor the length of care call visits, or if staff were late or didn't turn up. We found looking at the logs there were numerous late care call visits as well as staff not staying for the duration of the agreed times. There was no action plan or improvements planned to address this.

● The lack of effective auditing of the service meant they failed to identify where improvements were needed. We found concerns around recruitment; training and supervision; keeping people safe from harm, reporting concerns, lessons learned and general management and oversight of the service. Some of these areas had been audited by the registered manager, such as recruitment records, but they were not effective in making timely improvements. This put people at risk of not receiving safe quality care.

● The registered manager carried out medicine audits, however these had not identified concerns shared with us by relatives. Relatives told us they found medicines on the floor or some medicines not administered as prescribed although staff signed to indicate they had administered these. The registered manager's audits had not identified this so action had not been taken to re-train staff or check competencies. This meant people were left at risk of not receiving their medicines safely.

● We found the provider was not following the requirements by UK Visa's and Immigration when employing staff through sponsorships. They failed to ensure staff received clear information before leaving their own country. Some staff told us they experienced financial hardship after arriving.

● The registered manager shared a service improvement plan they developed, but this did not include any of the improvements identified above. We further requested the registered manager carry out audits of all the recruitment files and investigate concerns raised by staff or other stakeholders, where these concerns had not been investigated at the time. The registered manager told us they had fully audited the staff files. The investigation reports received from them were poorly completed, lacked detail and had no evidence of effective improvement actions and lessons learnt.

● The lack of effective recording and actions taken meant we could not be assured that people were supported safely. The provider had not been able to produce all the documentation we had requested to demonstrate they were meeting regulatory requirements.

The provider failed to ensure that systems and processes were robust enough to ensure people received

safe and quality care. This was a further breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Notifications of significant events are required to be submitted to the Care Quality Commission. Significant events include where people may have suffered an injury, been placed at risk of harm, or passed away. The provider had failed to notify CQC of these events as required.

Failure to notify CQC of reportable events is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Working in partnership with others

● The systems and processes operated by the registered manager and provider did not promote an open and transparent approach. Information we requested was delayed, at times inaccurate and in some circumstances developed only in response to our request. For example, recruitment file audit and investigation of safeguarding concerns. We also found discrepancies in the information the registered manager shared with us as part of our inspection in March 2022 and the current inspection. For example, the full staff list showed several discrepancies in the information provided to us.

● We saw evidence that the service worked in partnership with other health and social care professionals involved in some people's care.

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 18 Registration Regulations 2009 Notifications of other incidents The provider and the registered manager failed to notify CQC of reportable events.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager and the provider failed to ensure staff were appropriately trained and were competent to provide people with safe and effective care.

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	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider and the registered manager failed to operate effective safeguarding processes, and this left people at risk of abuse.

The enforcement action we took:

We issued a warning notice to ensure the provider and registered manager made the required improvements in a timely manner.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure they had robust systems and processes in place for people to receive safe and good quality care from staff who were adequately trained and skilled in meeting people's needs safely.

The enforcement action we took:

We issued a warning notice to ensure the provider and registered manager made the required improvements in a timely manner.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered manager and the provider failed to operate robust and safe recruitment processes. This meant there was a risk that not all the staff had the right to work in the UK or had the necessary skills and experience to meet people's needs safely.

The enforcement action we took:

We issued a warning notice to ensure the provider and registered manager made the required improvements in a timely manner.