24/7 Flex Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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
24/7 Flex Care Ltd is a domiciliary care agency providing personal care. The service provides support to older people and younger adults with dementia, learning disabilities or autistic spectrum disorder, physical disability, and sensory impairment. At the time of our inspection there were 11 people 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. At the time of our inspection, 10 people were receiving personal care.

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

Right Support: People did not always receive safe care. Risks to people's wellbeing had not always been identified or mitigated. This placed people at risk of harm. Medicines were not managed safely. Staff lacked training and not all staff had been recruited safely.

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 lack of policies and systems in the service allowed this practice to take place.

Right Care: Care plans failed to record accurate and consistent information about people. This made it difficult for staff to ensure people received the right care.

Right Culture: A closed culture had developed within the service. This meant people were more likely to experience harm. The attitudes and behaviours of leaders did not ensure the service was well led.

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 inadequate (published 14 December 2022) and there were breaches of regulation. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. 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 remained Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 24/7 Flex Care Ltd on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to gaining consent to care, safe care and treatment, keeping people safe from harm or abuse, staff training, recruitment practices, good governance, and the provider's openness and transparency.

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
The overall rating for this service is 'Inadequate' and the service remains in 'special measures.' This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our safe findings below.

24/7 Flex Care Ltd

Detailed findings

Background to this inspection

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

Inspection team
This inspection was completed by 3 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.

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
The first day of inspection was announced. We gave the service 24 hours' notice of the inspection. This was because the service is small, and we wanted to be sure there would be staff at the service to speak with us.

The second and third days of inspection were unannounced.

Inspection activity started on 2 May 2023 and ended on 16 May 2023. We visited the location's office on 2 May, 11 May and 16 May 2023.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 used all this information to plan our inspection.

During the inspection
We spoke with 2 people and 2 relatives about their experience of care provided. We spoke with 6 members of staff, including the registered manager.

We reviewed a range of records. This included 9 people's care plans and associated documents. We reviewed 17 staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection, the provider had failed to ensure risks associated with people's care were clearly identified. 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.

- Risks associated with people's care and support were not always identified and measures were not recorded clearly on how staff could reduce the risk of harm to them. For example, a person was at an increased risk of falls due to medication side effects and had been diagnosed with a health condition which increased the risk of bone fractures. No falls risk assessment had been put in place. This meant staff did not have guidance on how to support the person to mitigate the risk of falls and injury.
- Diabetic risks were not fully assessed, or clearly documented. One person's care record contained conflicting information regarding their diabetes, and who was managing this. Additionally, the person frequently declined food at the time of the carer's visits, however, their care records or diabetic risk assessment did not detail how this could affect the person's blood sugar levels, and what action to take in this event. The lack of sufficient care planning placed people living with the condition at increased risk of becoming unwell with poorly managed diabetes.
- Fire risks and emergency evacuation risks had not been identified and assessed. We reviewed 9 people's care plans, however only 1 person had a Fire Action Plan. This is the provider's document which gives guidance for staff to follow in the event of a fire in a person's home. Additionally, two people using the service smoked, which increased the chance of a fire happening. The provider failed to evidence fire risk assessments during the inspection. These were submitted after the inspection. However, they did not fully explain how to mitigate the risks associated with smoking.
- Risks associated with people's wellbeing had not been identified or reduced. One person suffered with low mood, however, there was no additional information to describe what that looked like, the risks posed to themself or staff, or the support staff were to provide.

The provider failed to adequately identify, assess, and mitigate risks to people using the service. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider's infection prevention and control policy was up to date.

Using medicines safely

At our last inspection, the provider failed to ensure medicines were managed safely. This was a breach of Regulation 12(2) 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(2).

● Medicine records contained conflicting information. One person had 3 places in their care records where prescribed medicines were listed. All 3 lists contained different medicines, which meant it was unclear which medicines the person was currently prescribed and taking. Multiple other medicine discrepancies were identified in other people's care records.
● Side effects for some people's prescribed medicines had been listed in their care plan. This was to support staff to identify any adverse reactions to medicines. However, there were no actions for staff to take if a side effect was identified. Furthermore, some side effects could present similarly to a person declining with a diagnosed health condition, for example, a side effect of confusion, in a person with dementia. Staff had no information on how to differentiate between a side effect, or a decline in the person's long term health condition. This placed people at risk of unidentified declines in their health.

The provider failed to ensure the proper and safe management of medicines. This was a continued breach of Regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At the last inspection, the provider failed to protect people from abuse. This was a breach of Regulation 13 (Safeguarding people from abuse) 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 13.

● The provider did not have sufficient systems to identify, report and respond to safeguarding concerns. This placed people at risk of abuse as there was a risk it would not be recognised or acted upon.
● Daily care records for 1 person described how they were experiencing physical pain on 2 separate days. We found no evidence staff had acted appropriately to support the person or to seek medical advice or attention. These neglectful actions by staff meant the person was subject to periods of poorly managed pain.
● One incident occurred where a person's catheter came out. The provider failed to provide evidence during the inspection that an investigation was conducted into this, to ascertain whether this was the result of the person self-harming, or poor practice by staff members. The incident had not been shared with the local safeguarding team or reported to CQC. We have raised 2 safeguarding referrals as a result of the findings from this inspection.
● Staff completed training in safeguarding, however this was not always effective as staff did not recognise safeguarding incidents. For example, a staff member told us, "I've had safeguarding training, but I've never had to report anything." Our findings throughout this inspection found safeguarding incidents had occurred. Staff failed to recognise incidents and protect people from improper treatment.

People remained at risk of improper treatment, through a lack of safeguarding incidents being identified

and investigated. This was a continued breach of Regulation 13 (Safeguarding people from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection, the provider failed to have an established recruitment system in place and was unable to demonstrate safe recruitment checks had been sought for all staff. 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.

● Staff were not recruited safely. This is the third consecutive inspection where the provider has failed to demonstrate safe recruitment practices.
● Multiple staff had references missing, and gaps in their employment history. This meant the provider could not be assured of the person's background and whether they were suitable to work with vulnerable people.
● Not all staff had ID badges. This was evidenced as a point in a recent team meeting, and in feedback from staff. One staff member told us, "I've stopped asking now [for an ID badge] I've given up." The lack of staff identification meant people were unable to check if the member of staff visiting them was genuine.

The provider failed to operate robust recruitment procedures. This was a continued breach of Regulation 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff did have evidence of DBS checks in place. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● Staffing levels were not clear. Information provided by the registered manager differed to data on the provider's computer system. This meant it was not easy to determine if there were enough numbers of staff to provide care to everyone. At the time of our inspection, the provider's care planning system showed 16 staff working.
● Systems to monitor care call times failed to be effective at the previous 2 inspections. Care call data was requested as part of this inspection; however, the registered manager provided inspectors with inaccurate data. We were therefore unable to report on whether there had been any improvement in these systems at this inspection.

Inadequate

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 inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance

At the last inspection, the provider failed to ensure people's mental capacity had been assessed and best interest decisions were in place where appropriate. This meant the provider was in breach of Regulation 11 (Need for consent) 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 11.

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.

- People's mental capacity was not assessed competently. For example, one person's mental capacity assessment had not been completed, however the form recorded the person lacked capacity and was unable to make decisions. When we spoke with the person's next of kin, they advised their relative did have capacity to make decisions. Two further people had also been assessed incorrectly and deemed to lack capacity. These incomplete and unclear assessments of people's mental capacity meant staff may have restricted them by making unnecessary decisions on their behalf.
- The principles of the MCA were not always followed. Where people were assessed to lack capacity, no best interest decisions had been made. This impacted on staff understanding how best to support a person when they were not able to make a specific decision independently.
- Consent to treatment and care forms were completed inconsistently with people's mental capacity outcomes. This meant staff did not know whether people had given their consent to receiving care and

treatment.

The provider failed to competently assess people's mental capacity, and work within legal guidelines. This was a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

At the last inspection, the provider failed to ensure staff had the necessary training and competence to deliver safe care to people. This meant the provider was in breach of Regulation 18 (Staffing) 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 18.

● Staff did not have the necessary training required to care for people's specific needs. Some people using the service had specific health needs, which staff members had not received training for. This meant people were at risk of undetected deterioration in their health as staff may not be able to identify when people's conditions worsened.
● Competency assessments had not been completed to ensure staff have implemented and maintained the required knowledge and skills to support people safely.
● Staff performance was not monitored closely. When monitoring had occurred, issues that had been identified had not been followed up to prevent reoccurrence. This placed people at risk of harm as a result.
● Spot checks of staff practice were carried out infrequently and failed to identify the shortfalls we found in relation to the quality of care calls and potential risks to people.
● Staff were not always supported through regular supervisions. Appraisals and supervisions took place sporadically. We found some staff who had not had regular supervisions, and another staff member who had records showing they had received 2 supervisions in 2 days. This meant, staff did not have a formal process between staff and managers where staff can review their workload, monitor and review performance, and identify any learning and development opportunities.

The provider failed to ensure training needs for staff were met, and staff were regularly supported. This is a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessment of risk was not always detailed. Risk assessments on people's care files were not always individual and often used standard phrases.
● Some people's care plans contained limited information regarding the tasks staff were required to carry out. Therefore, people's needs were not always accurately assessed and documented in their care plans.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider was unable to provide robust evidence of effective partnership working to improve outcomes for people using the service. We were told of one example where a person's GP had been consulted, and this resulted in a change to the person's prescription medication. The provider failed to keep records of this happening, and the person's care plans, and medicine administration records had not been updated to reflect the change of prescription.

● Information in care plans regarding other healthcare professionals was unclear and lacked essential details. This meant it was difficult for staff to know which healthcare professional was responsible for areas of people's care.

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

● People were supported to eat and drink enough. Daily care records demonstrated staff prepared full meals or snacks to meet people's dietary requirements.

● Where people wished to remain as independent as possible, records showed staff supporting them with some meal preparation, which then enabled the person to cook independently later in the day.

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 inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Throughout the inspection there was a lack of openness and transparency have lacked. When inspectors telephoned to announce the inspection, the registered manager advised a new computer system was due to go live the day after the inspection and requested to delay the inspection. The inspection went ahead as planned, and when inspectors arrived onsite, it transpired the new system was not due to begin for some time.
- The provider and management team obstructed inspectors in the course of their duties. Information was not readily shared; some information was removed from computer systems and several site visits were required to establish facts about the service provided.
- The registered manager failed to be transparent about an incident that affected a person who used the service.

The failure of registered persons acting in an open and transparent way was a breach of Regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our last inspection, effective and robust quality monitoring systems were not in place. The provider failed to ensure they had good oversight of the service. This was a breach of Regulation 17 (Good Governance) 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 17.

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

- This was the third consecutive inspection where the provider has failed to meet the regulations. There have been repeated breaches in relation to safe care and treatment, need for consent, fit and proper persons, and good governance across all 3 inspections. The provider's systems and processes had failed to identify the concerns found during the inspection.
- The provider failed to understand their legal requirement to operate within legally imposed conditions. During the inspection, multiple breaches of the provider's registration conditions were identified.
- The registered manager was not known to all people, relatives, and staff. This has been a continuous issue at all inspections of this service. One member of staff who has worked at the service for more than 1 year

stated she has only seen the registered manager once. A relative told us, "I speak with [office manager] as they organise the programme, arranging times, planning and also the overall qualitative issues. The other manager [registered manager] is responsible for invoicing, CQC matters and documentation." This meant the registered manager lacked oversight as people may not have shared information with them.

● Effective quality assurance systems were not in place. Only audits of the daily care notes and medicine records were completed, by the care coordinator. These both failed to identify issues found during this inspection. The registered manger failed to review these audits. The lack of a robust audit system meant the provider failed to identify all the issues within the service. This was a missed opportunity to remedy these issues and drive improvements within the service.

● The provider failed to ensure safe recruitment procedures were followed. The provider also failed to ensure staff had the training and supervision required to complete their roles. This placed people at risk of receiving care from staff which had not been proven to be of good character or had the skills and knowledge to provide safe care.

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

● A closed culture was prevalent within the service. This meant people were more likely to be at risk of deliberate or unintentional harm. Examples of this closed culture included the workforce comprising of family members or close friends, the registered manager not leading by example, staff being unwilling to speak to inspectors during the inspection, and those who did speak to us, fearful of repercussions.

● The provider's systems and processes failed to ensure consistent information was recorded in people's care plans and risk assessments. This made it difficult for staff to ensure people's needs were met.

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

● The registered manager told the inspection team that quality feedback surveys had not been sent to people or their relatives. We were also unable to find any evidence of telephone calls to assess people's satisfaction or dissatisfaction with the service.

● We saw limited evidence of the provider working with in partnership with others. The registered manager was given the opportunity to provide further evidence to demonstrate this, however the piece of evidence submitted, only demonstrated a lack of partnership working with the Local Authority.

The provider failed to have systems and processes to ensure good governance of this service. This was a continued 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

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's mental capacity was not assessed competently.

The enforcement action we took:

We served a Notice of Decision to cancel the Provider's registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care and treatment. Medicines were not managed safely.

The enforcement action we took:

We served a Notice of Decision to cancel the Provider's registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of harm and abuse.

The enforcement action we took:

We served a Notice of Decision to cancel the Provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not well-led. The registered manager lacked oversight.

The enforcement action we took:

We served a Notice of Decision to cancel the Provider's registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and

	proper persons employed Staff were not recruited safely.

The enforcement action we took:

We served a Notice of Decision to cancel the Provider's registration.

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider lacked openness and transparency.

The enforcement action we took:

We served a Notice of Decision to cancel the Provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have sufficient training and competence to meet people's needs.

The enforcement action we took:

We served a Notice of Decision to cancel the Provider's registration.