

First Choice Care Agency Limited

Geraint House

Inspection report

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20 December 2021

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Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	Inadequate ●
Is the service well-led?	Inadequate ●

Summary of findings

Overall summary

About the service

Geraint House is a domiciliary care agency which provides care and support to people living in their own homes. 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. At the time of the inspection 21 people were supported with personal care and one person was supported in other ways.

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

Care plans and risk assessments were not completed or reviewed in line with the provider's policy, this included catheter care plans and pressure area risk assessment charts. This put people at risk of harm of unsafe care.

There was a lack of medicine administration records, detailing the type and dosage of medicines. People were at risk of not receiving their correct medicines because medicines were not managed safely. The provider did not recognise the importance of ensuring correct administration of medicines and so had not mitigated risks around medicines. We have identified this as an area requiring improvement.

We were not assured by the provider's infection prevention and control (IPC) processes. The IPC policy did not mention COVID-19 and we were told by people who were supported by care workers, they had witnessed staff not wearing masks correctly.

Lessons had not always been learnt when things went wrong. Complaints were not logged in an effective way.

People and their relatives told us staff did not always stay for their full care duration and either arrived at their calls too early or too late. There is no call monitoring system in place, so the provider lacked oversight of this.

Records reviewed were not always complete or legible. The provider did not have effective systems and processes in place to identify this or to enable them to identify risks to people's health, safety and welfare.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
The last rating for this service was good (published 13 February 2020).

Why we inspected

We received concerns in relation to staffing. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe 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 Geraint House on our website at www.cqc.org.uk.

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.

At this inspection we have identified breaches in relation to need for consent, safe care and treatment, good governance, staffing and receiving and acting on complaints.

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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate ●

Geraint House

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

One inspector attended both days of inspection, and a second inspector attended day one, with a different second inspector on day two. This meant there were a total of two inspectors each day on site. A further inspector who was based off site, made calls to staff, people and their relatives.

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 18 hours' notice of the inspection. This was because the service the service is small, and we wanted to make sure staff would be on site on the day we inspected.

Inspection activity started on 16 December 2021 and ended on 21 December 2021. We visited the office location on 16 and 20 December 2021.

What we did before the inspection

We reviewed information we had received about the service. We sought feedback from the local authority. We contacted the local commissioners who work with the service to gain feedback of their experience. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with five relatives and two people who use the service about their experience of the care provided. We spoke with six members of staff including the provider, care coordinator and care workers.

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

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at daily records for a further person and gained clarity about the management of medicine.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The support people needed with their health conditions was not always identified in care plans. For example, one person had a catheter but there was no guidance for staff to follow to ensure they were supporting them safely and mitigating risks.
- Another person's risk of developing skin damage was not identified in care plans and so staff did not have guidance to follow to ensure this was monitored.
- People were at risk of being moved in a way that was unsafe for them. Staff did not have clear guidance about how to mobilise people within the care plans.
- People were at risk of not receiving the care they needed to support them with their diabetes. Diabetes care plans were not in place for all people who have diabetes. This meant there was a risk staff would not recognise a person who was unwell with their diabetes.

Care and treatment must be provided in a safe way for service users. The provider had failed to do all that was reasonably practicable to assess the risks to the health and safety of service users and to mitigate any such risks. This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely

- People were at risk of not receiving medication as prescribed as there was no record of whether the medicine was given or refused. Medication administration records (MAR) also did not include the name or dose of the medicine prescribed.
- One person told us they had a controlled-drugs patch applied weekly by their care worker, whilst the provider reported the care worker did not support the person with their controlled-drugs patch. As this was not listed on the MAR chart, it was not possible for the care workers to reliably know when the patch was to be removed and a new one applied.
- Observations of practice for medicines, to check competency of staff, were completed but were basic. The staff member completing the checks had not received training in medicines, according to the training matrix. This meant staff competency in medicines may not be accurately assessed.
- We found one person used nourishment drinks to supplement their diet. Records did not indicate if the drinks had been prescribed and staff did not record when they had given one to the person. This placed the person at risk of being given too few or too many of the supplement.
- Some people had been prescribed medication to thin the blood. There was no guidance about the side effects or what staff should look out for in case of injury, in people's care files.

People were at risk of not receiving their correct medicines because medicines were not managed safely.

This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- The provider's infection prevention and control (IPC) policy had not been reviewed to include COVID-19.
- Personal protective equipment (PPE) was not used effectively and safely. One person told us their care worker was not wearing masks from "when things relaxed a bit this year". We saw a staff member not wear a mask in line with guidance whilst they worked in the home care office. This put people at risk of infection.
- There was no record of staff testing. We were told by the provider that a staff member would inform them if a result was positive.

People were at risk of being exposed to infection because infection prevention and control processes were not documented or fully embedded by staff. This was a breach of Regulation 12 (Safe Care and Treatment) 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

- There were a lack of systems in place to ensure all safeguarding was referred to the local authority. We saw a record of two safeguarding incidents which had been investigated, but another safeguarding incident we and the provider had been notified of by a member of the public, was not recorded in the safeguarding log.
- Safeguarding that occurred at the service and had been investigated was followed up in a team meeting, but was not reviewed in depth to establish how staff would prevent it happening again.
- Staff were mostly knowledgeable about safeguarding adults and told us how they would identify and respond to allegations of abuse. One staff member was not aware what whistleblowing meant or what the whistleblowing policy and procedures was. Whistleblowing is the process of reporting wrongdoing in confidence to a staff member's employer or a higher authority.
- Feedback received from people and their relatives mostly reflected they felt safe being supported by the care workers. One person said about their relative, "Yes she is safe" and about the care worker, "She is very friendly and very good".

Staffing and recruitment

- People and their relatives told us staff often did not stay for their full call duration and often arrived much earlier or later than their scheduled call time. We were told that the impact of this for one person was that they are missing meals, as the morning call was so late, they were not hungry by lunch time and as a result, they would not eat lunch and have lost weight. Another relative told us that their next of kin was supported by calls which were too early throughout the day, so they stopped the morning and night-time calls despite really needing these calls.
- On inspection we saw evidence staff attended calls up to three hours earlier than the agreed time. This meant some people were supported in the morning as early as five o'clock and calls then fell earlier throughout the day, so tea-time calls were recorded at one in the afternoon. We spoke to relatives of people who lacked the ability to understand the timings of the calls, who were not aware this was happening. This was due to both a lack of staff and a deployment issue from the provider, as there was no oversight of this.
- One relative told us that sometimes one care worker did personal care on their own when two care workers were scheduled. We saw evidence of one care worker signing care records to say they attended a call, when two care workers should have signed to say they attended. This put people and staff at risk of injury or neglect, as the care worker would not support the person appropriately on their own.
- Staff were not up to date with Basic Life Support (BLS) training. This put people at risk of harm should they require BLS care when they are being supported by care workers.

There was not sufficient staff who had been appropriately trained employed at the service, this put people at risk of harm. This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Checks had not always been made to ensure staff were suitable for their roles. For example, we reviewed four people's staff files and there was appropriate references completed in just one staff file. The provider's policy stated that two references should be completed prior to a care worker starting their role and this did not always happen.

There were not sufficient checks in place to ensure people were fit to be employed. This was a breach of Regulation 19 (Fit and proper persons employed) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Disclosure and Barring Service (DBS) checks were made before staff began work. DBS checks identified if prospective staff had a criminal record or were barred from working with adults.

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 good. At this inspection this key question has now deteriorated 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had a legal responsibility to provide access to records for the inspection. At inspection, the provider, who is also the registered manager, refused to attend the service on day one of the inspection or to facilitate access to records on day one, despite being given notice of our visit. This obstructed the inspection as it did not promote our full insight of the service.
- It was unclear if safeguarding incidents had been reported correctly to the Care Quality Commission (CQC). The provider described the times when they should notify CQC of any concerns about safeguarding but they said, "I am not very good at that" about their role with safeguarding reporting.
- The provider failed to have systems and processes in place to identify records, relating to the care and treatment of people using the service, were not always fit for purpose. For example, people were put at risk of harm because staff lacked guidance which reflected people's needs and how to respond to risk.
- The provider failed to have effective oversight of care records. They did not identify records were not always legible. For example, daily care records viewed were of poor quality as we could not always read what care tasks had been performed or how staff engaged with a person.
- The provider had not ensured the confidentiality of information. Records relating to former employees and the planning and delivery of care had not been stored securely and in line with legislation and guidance at the registered location. Systems and processes did not support the confidentiality of information.

Continuous learning and improving care

- We were not assured the provider had adequate systems for calculating and monitoring hours that staff had worked. The provider did not have any system in place to monitor calls. The provider has a duty to monitor calls to ensure staff arrive on time and stay for the required time. It also meant where people and relatives reported that calls were being cut short, or staff were calling too early or late, the provider had no oversight of this and as such no improvements were made.
- The provider did not have effective systems and processes to enable them to identify risks to people's health, safety and welfare. We requested audits but the provider failed to produce any completed audits during our inspection. This meant the provider was not able to identify where quality and safety had been compromised and improvements were needed.

Records were not always fit for purpose and the provider did not ensure they had an effective audit and governance system. This was a breach of Regulation 17(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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; Working in partnership with others

- The provider lacked oversight of capacity assessments. For example, one service user's records said they could not make any decisions, but their consent to care had not been assessed in line with the Mental Capacity Act (MCA) 2005. The MCA is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. It includes the fact that a person may have capacity to make some decisions, for example about what clothing they want to wear that day but may not have capacity to make certain other decisions, such as large financial transactions.

The provider did not ensure they had an effective system in place to assess capacity of the people they supported. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The provider did not have an effective system and process in place to monitor complaints. This meant feedback received was not used to improve the quality and delivery of care. Whilst complaints were recorded in a logbook, there was no action as a result of this, meaning lessons were unlikely to have been learnt.
- We received mixed views from staff about the responsiveness of the provider to concerns that staff have shared. One care worker told us the provider listened but did not make any changes as a result. Whilst some care workers felt the manager was a good listener and a responsive leader.
- People and their relatives also gave mixed reviews about the action of the leadership in response to concerns raised. We were told by one relative that they had repeatedly raised concerns about punctuality, "but nothing changes". Whilst another relative reported, "anything raised with the manager has always been resolved".

The provider did not ensure they had an effective system in place to assess and respond to complaints. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- There was no record of professional's interactions with the service, other than a phone logbook for all telephone contact. This meant it was not possible to identify any evidence that people's health professionals were consulted, and that advice is followed where appropriate.

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 had not fully understood their responsibility under the duty of candour. They told us the duty of candour requires providers to be open with people when things go wrong with their care. However, they failed to mention the importance of giving people support and truthful information.

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 11 HSCA RA Regulations 2014 Need for consent</p> <p>People who use the service were not supported to make decisions in line with the Mental Capacity Act 2005.</p> <p>Regulation 11 (1)</p>
Personal care	<p>Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints</p> <p>The provider has not taken steps to act on complaints they received. This placed people at risk of harm.</p> <p>Regulation 16 (1)</p>
Personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>The provider did not have robust systems in place ensure the safe recruitment of staff at the service.</p> <p>Regulation 19 (1)</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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken all practicable action to mitigate risks. This put people at risk of harm. Regulation 12 (1)

The enforcement action we took:

Warning notice was issued

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken all practicable action to mitigate risks. This put people at risk of harm. Regulation 12 (1)

The enforcement action we took:

Warning notice was issued

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to effectively monitor and improve the quality and safety of the service. This put people at risk of harm. Regulation 17 (1)

The enforcement action we took:

Notice of decision issued

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to effectively monitor and improve the quality and safety of the service. This placed people at risk of

harm.

Regulation 17 (1)

The enforcement action we took:

Warning notice was issued

Regulated activity

Personal care

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not ensured there were adequate numbers of suitable staff employed.

Regulation 18 (1)

The enforcement action we took:

Issued a Notice of Decision