

Litch Care Services Limited

Litch Care Services Limited Liverpool

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

About the service

Litch Care Services Limited Liverpool is a domiciliary care agency providing personal care to people living in their own homes. At the time of our inspection there were 2 people being supported by the service. Not everyone who uses the service receives 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

People were exposed to avoidable risk of harm as systems to ensure the safe and proper management of medicines were inadequate. Records for the administration of medication were not always completed and we were not assured all relevant information was included on medication administration records (MAR) to enable staff to safely administer medicines.

Service users were at risk of receiving unsafe care and treatment as care plans and risk assessments were not adequate or up to date. Medical and health needs were not properly described, or risk assessed; information about service user needs and care was contradictory placing people at risk of inappropriate or unsafe care.

Assessments of people's individual needs had not been consistently recorded and did not consider best outcomes for people. Care plans were not person centred and did not hold sufficient information to guide staff when supporting people. The provider had not fully explored how to present information in an accessible way to meet individual needs.

Robust recruitment practices were not followed. Systems to support and develop staff did not ensure they had the knowledge and skills needed to support people safely and effectively. Conflicting information was provided by management for permanent staff employed at the service and records demonstrated inaccuracies.

Feedback from a family member was positive about the support provided and felt the registered manager was responsive. We were told staff enabled people to make their own decisions and offered choice when carrying out tasks. Management, however, did not demonstrate a clear understanding of the Mental Capacity Act 2005 and the service was not working within the principles of the Mental Capacity Act. (MCA). Records did not clearly evidence capacity had been assessed and decisions were made in the people's best interests.

Governance systems were ineffective. The provider had failed to implement systems to assess, monitor and improve the service. Audits and checks completed by the registered manager had not identified the issues we found during this inspection. The registered manager failed to demonstrate knowledge and understanding of their role, quality performance, risk and regulatory requirement.

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 Inadequate (published 12 October 2022). At this inspection we found the provider remained in breach of regulations regarding the management of medicines, risk management and the governance of the service.

Why we inspected

We carried out an announced inspection on 16 and 20 November 2023 following on from breaches that were found at the previous inspection in October 2022. The provider completed an action plan after the last inspection to show what they would do and by when to make improvements.

We undertook this focused inspection to check improvements had been made and if the provider now met legal requirements. 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 comprehensive inspection to calculate the overall rating. The overall rating for the service has remained as inadequate. This is based on the findings at this inspection.

Enforcement and Recommendations

We have identified breaches in relation to safe care and treatment, fit and proper persons employed and governance at this inspection.

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

Special Measures

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

If the provider has not made enough improvement within this time frame 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.

<p>Is the service safe?</p> <p>The service was not safe.</p> <p>Details are in our safe findings below.</p>	<p>Inadequate ●</p>
<p>Is the service effective?</p> <p>The service was not effective.</p> <p>Details are in our effective findings below.</p>	<p>Inadequate ●</p>
<p>Is the service well-led?</p> <p>The service was not well-led.</p> <p>Details are in our well-led findings below.</p>	<p>Inadequate ●</p>

Litch Care Services Limited Liverpool

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.

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 who was also a director of the company and the CQC nominated individual.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection

We gave the service a short period of notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection

We reviewed information we had received about the service. We sought feedback from the local authority. We used all this information to plan our inspection.

During the inspection

We spoke with one family member. We spoke with three members of staff including the registered manager. We reviewed a range of records. This included two peoples care records and medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including governance records and policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same.

At the last inspection, the provider was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people were not always safely assessed and mitigated to maintain people's safety.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- We were not assured the provider was keeping people safe through assessing and managing risks to people's health and safety.
- Risks to people's physical health were not assessed, monitored, or managed safely. Not all People had relevant or effective risk assessments in place.
- We identified significant risks from people's care records that risk management strategies were either not clear or did not exist. For example, those at risk of falls did not have a falls risk assessment in place or a care plan to reflect how this risk was to be managed.
- Care plans were conflicting and lacked detail on how to support people in a way which would mitigate risk. There were no care plans in people's homes. This meant staff did not always have access to information about people's care and support needs.
- Environmental risk assessments were not in place to ensure staff had sufficient information available to them regarding any risks. For example, in the event of an emergency where to switch off the water, electricity or gas. Also, to identify any hazards inside or outside the person's home they were visiting.

A failure to ensure risks associated with people's care was assessed and plans implemented and delivered to mitigate such risks 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 did not receive their prescribed medicines safely.
- We identified staff were administering medicines in the absence of appropriate records being kept. For example, there were no records detailing medicines prescribed for people. One person required medicines to be administered at a specific time. Records were kept of when staff administered medicines.
- Staff were administering PRN medications that were not recorded on a medication administration record and the provider had not provided staff with written guidance via PRN protocols for 'as required' medicines.
- Medicines competency assessments were incomplete for staff. Training and assessments of staff competency had not been effective to ensure practice was safe. One staff was assessed as competent, however further training was identified and not completed.

- A staff member told us, "I would like more training on medication administration".

Systems to ensure the safe and appropriate management of medicines were not in place or not adhered to. This placed people at risk of harm. This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The provider had not followed safe recruitment practices. Gaps were found across recruitment records, including within application forms and references not sought from details provided.
- Records of other staff members providing personal care were observed within the visit records at a person's home. This did not match with the providers account of people who worked for the service.
- Staff competencies were ineffective. A personal assistant competency assessment had been completed for the two staff members employed and deemed as competent, however the records stated more training was needed.

The provider did not operate robust recruitment processes. This is a breach of Regulation 5 (fit and proper persons employed) 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

- Not all staff had received training in safeguarding adults to ensure they knew how to identify and report abuse concerns. Risk assessments had not been undertaken to protect people from abuse and improper treatment.
- A staff member spoken lacked understanding in relation to their role and responsibilities for safeguarding. The staff member was not aware of how to make a safeguarding referral and thought this was the role of the provider.

Systems and processes in place to safeguard people from the risk of abuse were not followed or effective. This placed people at risk of harm. This is a breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- Staff had received training in infection prevention and control.
- A staff member was observed to be wearing PPE during a home visit.
- Spot checks were being completed on site during home visits by the provider.
- The providers infection prevention and control policy was out of date and had not been reviewed since 2021.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same.

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.

- The service was not working in line with the Mental Capacity Act, appropriate capacity assessment and best interest processes were not in place.
- Assessments observed were not decision specific and covered multiple decisions to be made.
- A staff spoken with had limited knowledge and understanding of their role and responsibilities under the MCA.
- Information within care plans was inconsistent with regards to people's capacity to make decisions and the registered manager lacked the understanding with regards to the Mental Capacity Act 2005 (MCA and legal framework).

The provider had failed to ensure the service was working within the principles of the MCA and that capacity was accurately assessed and recorded. This is a breach of Regulation 11 (need for consent), 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;

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

- Records evidenced gaps with assessments of people's needs. Some assessments were either out of date or conflicting.
- People's diagnosis was contradictory in their care plans, which made it difficult to understand if people's needs were being fully met.
- Care plans lacked detail around specific health conditions. This increased the risk of people not having their needs effectively met.
- Processes for updating care plans following a change in need were not effective. One person was under

review of a dietician following weight loss and was prescribed supplements. This was not recorded within a care plan and a nutritional risk assessment was not in place. This meant people were at risk as staff did not have access to all information about people's care and support needs.

The provider had failed to ensure that care plans accurately reflected people's care and support needs. This is a breach of Regulation 17 (good governance), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills, and experience

- Staff training records evidenced staff had completed multiple courses in 1 day.
- We found not all staff had received training in safeguarding, fire safety, equality diversity and human rights and dementia. This evidenced people were supported by staff who had not received training relevant to their role.
- Staff were enrolled onto the Care Certificate at the commencement of their employment and records evidenced staff had completed all 15 modules within five days. Skills for Care references the training should take around 12 weeks to complete, this did not demonstrate training was appropriately planned to promote staff learning.

Staff working with other agencies to provide consistent, effective, timely care

- Care plans did not hold sufficient information about people's health needs. Staff had little understanding of people's individual health issues and how these were supported.
- We were not assured the service was working with external professionals to ensure people received the right support as care plans lacked information regarding this.

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. Although the provider had made improvements, many were recent and they needed to be embedded and sustained to achieve an improved rating

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

- Governance processes were ineffective and failed to keep people safe, protect people's rights and provide good quality care and support. The provider had not identified the concerns we found at this inspection, including the lack of robust risk assessments in care planning processes, lack of person-centred care plans, unsafe recruitment procedures and gaps in staff training and competency assessments.
- Records including mental capacity assessments, medicine's records and staff records were not always accurate, complete and up to date.
- The provider was not clear about their role and regulatory responsibilities and was unable to demonstrate they could meet the fundamental standards of care

The provider had failed to ensure that governance systems were effective at driving improvement and that people's identified risks and needs were adequately assessed and care planned to ensure staff had access to accurate and up-to-date information. This is a breach of Regulation 17 (good governance), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

There was some evidence of client reviews by the provider, however there was no evidence the management team were working in partnership with other agencies.

- There was a lack of evidence to reference any changes to people's care needs by professionals was actioned by the provider.

Systems were not in place to monitor the quality and safety of the service to identify shortfalls in the provision of safe care. This is 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

- The reporting of incidents, risks, and concerns was unreliable or inconsistent. The systems in place for managing risks were ineffective and did not ensure people were protected from harm. We were told about incidents that had happened that were not reported, investigated or lessons learned identified by the provider.
- The registered manager and provider did not evidence they understood their duty to share information in an open and honest manner. Inconsistencies with regards to staffing and recruitment evidenced the inspection process was not approached with transparency.

- A relative told us they felt their loved ones felt safe and that continuity of care was provided.

Continuous learning and improving care

- The quality assurance systems in place did not drive improvements or identify some of the short falls found during the inspection.
- Care records did not always contain the relevant information that was required.
- There was no evidence of learning and reflective practice. There was no system or process that could identify these areas.

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 Systems in place to manage people's medicines were unsafe which placed them at risk of harm.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Personal care

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes in place to safeguard people from the risk of abuse were not followed or effective.

The enforcement action we took:

Notice of proposal.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to manage people's medicines were unsafe which placed them at risk of harm.

The enforcement action we took:

Notice of Proposal to vary a condition on your registration for the regulated activity Personal care

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively to ensure safe recruitment practices

The enforcement action we took:

Notice of proposal.